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CATASTROPHIC HEALTH INSURANCE: THE "MEDIGAP" CRISIS

A REPORT

BY THE

CHAIRMAN

OF THE

SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE

OF THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

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PREFACE

Since its creation in 1974, the House Select Committee on Aging and its Subcommittee on Health and Long-Term Care have been charged with the responsibility of conducting a continuing review of Medicare, the Federal Government's health insurance program for older Americans.

During my chairmanship of the House Select Committee on Aging, I called upon the committee staff to conduct an in-depth investigation into alleged abuse in the sale of Medicare supplementary insurance policies. The committee, in November of 1978, released the findings of its exhaustive investigation in a report entitled, "Abuses in the Sale of Health Insurance to the Elderly in Supplementation of Medicare: A National Scandal." This report documented for the first time the broad scope of abuses in health insurance sold to the elderly. Additionally, the report provided the committee and the Congress with a list of options and policy alternatives from which they could choose to bring about needed reform. On the basis of this report and the committee's findings, the Congress did, in fact, act to curb abuses by enacting legislation outlawing certain forms of abusive sales techniques in the sale of insurance to seniors and creating a voluntary certification program for policies sold in supplementation of Medicare.

It has been almost 8 years since the release of this landmark committee report. It has been 6 years since the passage of this reform legislation. For this reason, I called upon the subcommittee staff in 1984 and 1986 to conduct a review of insurance designed to supplement Medicare to determine whether abuses still persist and what impact, if any, the reform legislation has had in curbing the abuses we uncovered in 1978.

This report concludes that abuses in the sale of insurance to the elderly have not diminished, but in fact have increased; that a new voluntary certification program does little in the way of preventing insurance abuses; and that the States and the Federal Government should take remedial action.

The findings of this report come at a time when the Congress and the administration are looking for ways to remedy the anticipated solvency problems facing the Medicare Program and to improve the protection its seniors receive. Since 1981, the subcommittee has conducted a series of nationwide hearings addressing specifically the crisis in health care currently facing our country. These sessions examined the problem of rising costs and reduced benefits under the Medicare Program. They also examined the solvency of Medicare. Perhaps the most jarring revelation in these nearly one dozen hearings was the lack of coverage under private and public

health insurance for catastrophic illnesses such as Alzheimer's disease and cancer which may require costly extended care.

For this reason, in 1986, I called upon the Subcommittee on Health and Long-Term Care to commence a series of hearings on catastrophic health insurance for the purpose of developing a legislative proposal designed to both insure the solvency of the Medicare Program for years to come and to provide the much needed coverage for the long, drawn out illnesses such as Alzheimer's disease and many forms of cancer—coverage not currently provided by the Medicare Program or private insurance.

We initiated our series of hearings on catastrophic health insurance in February 1986. Dr. Otis R. Bowen, the newly appointed Secretary of the U.S. Department of Health and Human Services, appeared at that session, describing some of his ideas for reform. President Reagan, just days before our subcommittee hearing, had charged the new Secretary with developing a plan to meet the catastrophic health care needs of Americans of all ages. The subcommittee was encouraged by the President's new initiative, but was discouraged by reports that the administration's catastrophic insurance plan would fall far short of meeting the real bankrupting health catastrophies encountered by Americans. The administration's plan had concentrated on methods of assisting Americans pay hospital bills not paid by Medicare or private insurance. Yet, hearing after hearing by the subcommittee has documented the fact that Medicare and private insurance do a pretty good job covering hospital care. Only about 1 percent of older Americans would benefit from the administration's proposal. Dr. Bowen's testimony before the subcommittee did not discount the subcommittee's finding. Rather, he promised the subcommittee that he would consider all proposals to achieve needed reform during the coming year.

The second in our series of hearings brought testimony from the former Secretary of Health and Human Services, Joseph A. Califano, as well as a noted medical expert from Harvard Medical School, Dr. David Blumenthal. Both confirmed the subcommittee's finding that the real catastrophe for older Americans are bills associated with long, drawn out illnesses, chronic conditions from which the older American will not recover. Such conditions, they said, are bankrupting the chronically ill and their families because of Medicare's shortsighted reimbursement system. They urged the subcommittee to consider a reform measure designed to pay for reasonably priced, high quality health care for all types of illnesses, both in and out of hospital.

A third hearing was held in April 1986, in Chattanooga, TN, on catastrophic health insurance. Here again, the subcommittee heard sad stories of families left destitute after paying for their chronically ill relatives. They told the subcommittee how they felt their Medicare and private insurance would be sufficient to cover their health care costs when that need arose. They found out the hard way that no insurance plan can fulfill that promise when a long-term health catastrophe strikes. They urged the subcommittee to design health insurance protection that would give Americans the peace of mind currently unavailable in the health insurance marketplace.

"Catastrophic Health Insurance: The 'Medigap' Crisis" is the fourth in our series of hearings. In the development of a comprehensive catastrophic health insurance proposal, it is appropriate that we scrutinize the adequacy of public and private insurance currently available to older Americans.

The good work apparent in the report which follows could not have been possible without the help and support of many people. Most of all, subcommittee staff director Kathleen Gardner Cravedi, subcommittee assistant staff director Melanie Modlin and research director Peter Reinecke had the overall responsibility for directing this inquiry and preparing this report. In addition, Ronald Scheid, Lanny Miller and Robert Joy, detailees to the subcommittee from the U.S. Postal Service, Ronald Schwartz, detailee from the Inspector General's Office of the Department of HHS should be commended for their excellent work with the subcommittee through the duration of the investigation. Mrs. Lillian Simmons, a volunteer to the subcommittee, portrayed an interested senior citizen insurance consumer in the majority of insurance interviews undertaken by the subcommittee. Her contribution in this and numerous other facets of the investigation was invaluable.

Mrs. Margaret Dickson, who had helped the Aging Committee in its original Medigap investigation in 1978, returned as a senior investigator in 1986, for which I thank her.

Special thanks must also go to Laura Hart and William Schloss, interns from Duke University's Institute of Public Policy, and Chin Fa Chen, intern from Brown University, who assisted the subcommittee in all aspects related to the preparation of my report on Medigap abuses. Bill Halamandaris and Val Halamandaris made invaluable contributions during their tenure at the Committee on Aging, as did detailee Dayle Berke, fellow Patricia Butch, and interns Mary McNamara Bennett, Marcia Finkel, Andi Samuels, Bonnie Hogue, Marian Brown, Theresa Johnson, Liz Gatti, Catharine Wilson, Glen Stettin, Eve Subrin, Mark Hickman and Martin Schaeffer. Special thanks also to Rita G. Coleman, who gave up many days of vacation from her job at the National Association for Home Care in order to assist with production. All of these people performed activities in an admirable fashion.

I hope that this report will lead to swift enactment of sorely needed reform measures in the area of supplemental Medicare insurance.

CLAUDE PEPPER, *Chairman.*

GLOSSARY

Annual Premium: The total payment required in a year to keep a health insurance policy in force.

Basic coverage: Basic coverage generally provides reimbursement for the major expenses associated with illnesses of limited duration, although benefits for 120 to 365 days of hospital care are not uncommon. It typically limits coverage in terms of the maximum expenses or utilization of each particular service that is insured. A basic plan usually provides coverage for one or more of the following: hospital, inpatient physician visits, surgery, and outpatient diagnostic tests.

Benefit maximum: The limit a policy will pay for for a given benefit. A benefit can be expressed either as a length of time (for example, 60 days of semiprivate hospital room charges), or as a dollar amount (for example, $350 for a certain procedure).

Benefit period, or spell of illness: The period that begins the first day you are confined to a hospital or skilled nursing facility and ends when you have gone 60 days without being readmitted to either type of facility.

Coinsurance or copayment: A percentage of a health expense for which you are responsible after paying the deductible amount. A policy that uses coinsurance typically would pay up to 80 percent of a given expense, and you would pay the remaining 20 percent.

Conditionally renewable: The company will continue insuring you as long as it continues to insure people in your State with the same kind of policy.

Coordination of benefits (COB): A method of integrating benefits payable under more than one health insurance plan so that the insured's benefits from all sources do not not exceed 100 percent of allowable medical expenses.

Customary, usual and reasonable charge: The reimbursement from a private insurance plan is the typical charge for the service in the geographic area, determined on a statistical basis, and making allowance for the complexity of the case, or the amount actually or usually charged by the particular physician if less than the customary and reasonable charge.

Deductible: The amount of covered expenses which must be paid by the insured before benefits are payable by the insurer.

Duration of benefits: Most of these policies pay their cash benefits for 1 to 2 years, as long as you are hospitalized. Some pay for less than 1 year; some for an unlimited duration.

Dread disease policy: A policy providing coverage for a serious illness (most frequently cancer), in which benefits are usually tied to hospitalization that is, a flat fee is paid for each day of hospitalization). For this reason, most dread disease policies do not provide cost-effective insurance protection for senior citizens. The average cancer patient stays in the hospital only 7 days, and is hospitalized

only 1.8 times in a 2-year period. Therefore, a very small proportion of dread disease patients break even on the money paid in premiums.

Elimination period: Applies to a certain type of plan called a hospital income policy, in which benefits may not be paid under the elimination period for the first several days of hospitalization. Elimination periods vary from policy to policy and from company to company. The result is their length can be selected: the longer the elimination period, the lower the cost of insurance. But one is less likely to receive benefits for a short period of illness.

Entrance age: The age up to which the company will sell you a policy. Entrance ages vary considerably from company to company and some policies can be bought at any age.

Fee schedule: The insurance specifies the maximum dollar amounts that it will pay for a particular service.

First dollar coverage: Insurance plans or portions of plans which provide benefits without first requiring payment of a deductible.

Group policy: Specified benefits are provided to group members, and often their spouses and children, under a contract between the insurer and an organization, such as an employer, a labor union, or a voluntary association.

Guaranteed renewable: The company agrees to continue insuring you up to a certain age as long as you pay the premium; and it cannot raise your premium unless it raises premiums for a particular class, such as everyone in your geographical area with the same kind of policy. Some policies are guaranteed renewable for life.

Health maintenance organization: A community medical service plan. Its annual fee entitles a person to its health facilities, professional services, and supplies. HMO's which accept Medicare members compute the dollar value of your Medicare benefits, plus the value of your supplementary group coverage, and charge you in dollars what it takes to meet their annual fee.

Hospital income policy or hospital indemnity policy: This kind of policy pays its benefits in cash on a daily basis when you are hospitalized. Because Medicare covers most of the cost of up to 2 months of hospitalization, many people set aside the early benefits to these policies against out-of-pocket costs that develop later in a spell of illness.

Licensing: If the company is licensed to sell insurance in your State, you will have recourse to your State insurance commissioner should a dispute arise.

Lifetime maximum: A limit that some plans set on the total benefits they will pay over the life of the policy.

Lifetime reserve: Under Medicare's Hospital Insurance (Part A), benefits for 60 additional hospital days which can be used whenever a beneficiary has exhausted the 90 days covered in a benefit period. In 1986, lifetime reserve days are subject to a copayment of $246 per day.

Major medical coverage: Coverage designed to provide protection associated with more costly illnesses. It usually obligates the insurer to pay a specified portion of a wide range of medical expenses in excess of a deductible and usually is characterized by few internal limits for particular services and a high overall limit.

Medicare Part A (hospital insurance): The first part of Medicare (part A) is primarily a hospital insurance program. After you pay a deductible amount of $492, Medicare pays for 60 days of full hospital care for each spell of illness, including all of the charges customarily associated with a hospital bill, such as the semiprivate room rate, meals, regular nursing services, laboratory and X-ray fees, meals, intensive care costs, operating and recovery room, drugs, casts, dressings, splints and in-hospital therapy services.

If a spell of illness goes beyond 60 hospital days, you become responsible for a $123 daily copayment, up through the 90th day.

In effect, the program provides for most of the cost of 90 days of hospitalization for each spell of illness.

In addition, the program provides a 60-day lifetime reserve of hospital days against which you can draw, should any spell of illness extend beyond 90 days. You must pay $246 for each day you use the reserve.

Medicare Part A also pays toward extended care in a skilled nursing home, as well as part-time skilled nursing care at home. It works this way:

After a hospital stay of at least 3 consecutive days, Medicare helps pay for up to 100 days of extended care in a skilled nursing facility, provided that the nursing is certified as being connected with the illness that put you in the hospital. As with the hospital coverage, the nursing home benefit pays the charges normally associated with these facilities. The first 20 days of nursing home care are paid in full. The next 80 days of care requires a $61.50 daily copayment from you. Your eligibility depends upon your need for skilled medical services. The program does not cover custodial care in a nursing home.

Medicare Part A also provides for home nursing visits by skilled paramedical personnel. These benefits can include therapy, skilled medical services, and supplies and equipment provided by home health care agencies.

Medicare Part B (medical insurance): The second part of Medicare, the one you pay premiums for, helps pay for physician and surgeon services both in and out of a hospital.

It works this way.

After you have paid a $75 deductible amount, the program will pay for 80 percent of reasonable medical charges; you are responsible for 20 percent of those charges.

The key word here is "reasonable," and Medicare determines what is a reasonable charge. It could be considerably below a physician's normal fee. Some physicians accept that figure but others do not.

So the basic question to ask when seeking medical services is: Will your physician or surgeon accept Medicare "assignment"—that is, accept only what Medicare will pay the doctor?

If your physician accepts Medicare assignment, your out-of-pocket expenses will be: (1) the deductible amount; (2) the 20 percent coinsurance; and (3) the part of the doctor's charges in excess of Medicare's definition of a "reasonable" charge.

Aside from physician and surgeon benefits, Medicare Part B has a number of other benefits—most of them subject to the 20 percent coinsurance.

Medigap: Insurance purchased to offset the difference between what Medicare pays and the costs of medical care.

Nongroup policy: Provides coverage under a contract directly between the insurer and the insured individual or family obtaining the insurance.

Preexisting condition clause: A health problem you had prior to becoming insured. Policies with preexisting condition limitations will not pay benefits for treatment of prior health problems for a specified period of time.

Primary insured: The person in whose name the insurance is issued or carried, in contrast to any dependents covered by the insurance.

Private health insurance: Any insurance for medical or related expenditures but excluding extra cash coverage (small supplemental payments in the event of hospitalization); medical benefits linked to disease such as stroke or cancer (dread disease); and casualty benefits.

Reinstated benefits: Some policies will restore the lifetime maximum according to a specified schedule during periods when you are not drawing benefits.

Renewable at company option: The company reserves the right to stop insuring you as an individual. However, you cannot be cut off from receiving benefits under the policy in the midst of an illness.

Retirement associations: There are several associations of retired individuals that offer supplementary insurance. Membership fees in these associations are nominal and, in addition to offering insurance plans, they provide other programs of interest to retirees.

Typically, the health insurance plans they offer are wide ranging, permit enrollment regardless of previous health history and have fairly short waiting periods for preexisting conditions.

Waiting period: The period of time that must pass, after you become insured, before the policy will begin to pay benefits for a preexisting condition or certain specified illness.

Wraparound policy: This policy typically pays a high proportion of health expenditures Medicare doesn't pay for: first-day hospital deductible amount of Medicare Part A and the copayments that begin on the 61st hospital day. Such a policy may also pay the $75 deductible associated with Medicare Part B and the 20 percent copayment on physician and medical services you would ordinarily be responsible for.

Wraparound policies typically will pay for a substantial part of a number of other health services not fully covered or not covered at all by Medicare, such as out-of-hospital prescription drugs, medical appliances and equipment.

Often, these policies, in effect, extend the number of hospital days covered under Medicare and they may also pay for the copayments involved in a skilled nursing home day.

Wraparound policies vary somewhat from one another, but generally they fulfill their definition—that is they wrap around and fill in the gaps of Medicare.

INTRODUCTION AND EXECUTIVE SUMMARY

In November 1978, the House Select Committee on Aging released the results of its investigation of abuses in the sale of health insurance to the elderly in a hearing entitled, "Abuses in the Sale of Supplemental Insurance to the Elderly." The committee called the problem a national scandal of staggering dimensions. Testimony revealed that some insurance companies and their unscrupulous agents had become merchants of fear. Capitalizing on the anxiety about ever-escalating health costs, they have conspired to sell senior citizens multiple, unneeded, duplicative and therefore, essentially worthless insurance policies in supplementation of Medicare, the national health insurance program for the elderly.

A 444-page committee report, "Abuses in the Sale of Health Insurance to the Elderly in Supplementation of Medicare: A National Scandal," estimated that senior citizens were being taken for as much as $1 billion out of the $4 billion they spent for Medicare supplemental policies each year.

The report concluded that that root cause of the widespread abuse is the fact that senior citizens are afraid. Every day they face the double-edge sword of ever-escalating health care costs and constantly decreasing Medicare coverage. Every day they fear getting sick, going broke, going into a nursing home, or becoming dependent upon loved ones. Motivated by fear, they buy hope in the form of one or more insurance policies, not realizing that there is no policy or combination of policies that they could buy that would plug Medicare's gaping holes and provide them with the comprehensive coverage they desperately want. Understandably, senior citizens are ready victims for fast-talking insurance agents.

The committee found that it was not uncommon for senior citizens to have 3, 5, 10, 30 and in one instance 91 different insurance policies. In the most blatant example to come to the committee's attention, a 76-year-old Illinois woman paid over $50,000 in insurance premiums over 10 years and was forced to remortgage her farm to keep up with the premiums. The saddest part of the story was that most policies contained a clause which said that in the case where an individual has more than one policy, only one will pay.

Both the 1978 hearing and its study zeroed in on the pervasive abuse in insurance policies that claim to supplement Medicare. The study was the first detailed national investigation of this problem. It marked the first time that every State department of insurance and the great majority of companies selling Medicare supplemental insurance policies to the elderly had been surveyed. For the first time, large numbers of senior citizens had been asked about their problems with such policies. In addition, the committee conducted investigations in nine States and the District of Columbia: California, New Jersey, Pennsylvania, Maryland, Illinois, Georgia, Arizona, Delaware, and Virginia—which at the time accounted for half

of America's 23 million aged. Using volunteer senior citizen investigators, the committee developed firsthand information about how some companies took advantage of the fearful aged.

For example, Margaret Dickson, one of the committee's senior citizen investigators from the District of Columbia, got some unsettling advice from health insurance agents when she asked them to look over her collection of supplementary policies for Medicare.

Mrs. Dickson was overinsured, but most of the agents insisted that she buy even more coverage. Some dismissed her policies as garbage without even looking at them, and pressed her to replace them with as many as eight new overlapping plans. Mrs. Dickson said one agent grilled her about my tax bracket, "my banks, my general financial situation, and then suggested—oh heavens, I cannot say it—euthanasia as a solution to long-term health problems." He also asked her to give him power of attorney over her affairs.

What these agents didn't know was that Dickson, a retired receptionist for the committee chairman, was working with congressional investigators. Her son, who took photographs of the meetings, and the insurance sales trainee sitting in on them, were committee staff investigators.

In 50 such interviews, conducted during the fall of 1978, only 8 agents honestly advised, "Gee lady, I think you've already got too much insurance."

Dickson's case was not unique. Investigators found widespread misrepresentation of what policies pay for, high-pressure sales tactics, agents posing as Federal employees, agents persuading elderly persons to replace adequate policies with new ones just so that he or she could get a higher commission, and companies that paid out very little in benefits compared to the large amounts they collected in premiums.

In addition, the report detailed the activities of four staff investigators who obtained jobs with insurance companies in order to determine whether the abusive marketing practices were company policy.

The study concluded that there were widespread abuses with respect to so-called Medigap insurance policies and the manner is which they were sold to the elderly. It also concluded that there has been a failure to aggressively regulate such abuses by many State Insurance Commissioners. The study likewise concluded that most major insurance companies are not involved in the abuses which filled the report.

The abuses that were found were among the insurance companies who specialized primarily in the sale of individual not group policies. Even then, the most serious problems were generally found among the small and almost anonymous insurance companies that specialized in selling to the elderly.

Following the investigations and hearing by the House Select Committee on Aging, Congressman Claude Pepper introduced H.R. 2602, a bill to curb the proliferation of abuse in the sale of Medigap insurance. The bill, which enjoyed the cosponsorship of 265 Members of Congress, would do the following:

Establish a program of voluntary certification whereby those policies which meet or exceed Federal minimum standards

could be awarded a Federal seal of approval by the Secretary of Health, Education and Welfare. The Federal standards were those recommended by the National Association of Insurance Commissioners plus requirements for economic value. To qualify, group policies would have to return at least 75 cents on the premium dollar to the insured in the form of claims, and policies sold to individuals must return at least 60 percent of the premium dollar. The Federal seal would serve to guide senior citizens as to what is and what is not acceptable policy. The certification program would give the competitive advantage to firms with high standards and firms with policies which did not meet Federal minimums would be at a significant disadvantage in their sales. States which have enacted substantially equal or higher standards would be exempt from the program.

Make it unlawful for agents to indulge in two common abuses: overselling and the government look. There were no laws prohibiting an agent from deliberately overloading senior citizens with multiple policies or pretending to be from the Medicare program or from using advertising materials displaying the Federal eagle and giving the appearance of an official Government document. These practices would be outlawed under the bill. Violation would be a felony punishable by up to 5 years in jail and/or a $25,000 fine.

Help the States regulate mail order insurance. Under current law in 1977, the States could not effectively regulate Medicare supplementary policies which were sold by mail. The proposal would require mail order firms to first file their policies with the commissioner of insurance in the State in which it would be sold and obtain his or her approval before they could mail their policies into that State. Violation would be a felony punishable by up to 5 years in jail and/or a $25,000 fine.

The introduction of H.R. 2602 stirred up a strong lobbying effort against its enactment by opponents in the insurance industry. Even with strong bipartisan support for the reform legislation in the House, efforts to move the bill swiftly on the House side were stalled by effective lobbying forces. Staff of the House Select Committee on Aging met with the staff of Senator Max Baucus (D-Mont.) and former Senator John Culver (D-Iowa) to seek support for movement of the bill on the Senate side. Both Senators agreed to introduce S. 1295, a bill identical to H.R. 2602. Between December 5, 1979 and January 30, 1980, Baucus redrafted his bill to exempt from the certification program health insurance contracts established by employers or labor organizations. Baucus also went along with an amendment making clear that effective State programs could replace Federal certification.

The Baucus bill had strong political appeal and was adopted as an amendment to a Social Security disability bill approved by the Senate January 30, 1980. The House passed its version of the Baucus amendment May 22, 1980. And, on June 9, 1980, the voluntary certification of Medicare supplemental health insurance policies became public law (P.L. 96-265) (See appendix H). Among other things, the new law required that a program of voluntary certification for Medigap policies be established; that overselling and the government look as insurance practices be outlawed; that

mail order firms be required to first file their policies with the commissioner of insurance in the State in which the policy is sold; and that a study of State regulation of such insurance be undertaken by the Department of Health and Human Services.

It has been 6 years since the enactment of this landmark legislative reform measure. It has been 8 years since the committee's investigation into abuses in the sale of insurance to the elderly. The purpose of this report is to determine the status of the Medicare program in America today, both in terms of its future solvency and its current benefit structure; to identify Medicare's shortcomings and gaps in coverage; to examine the role of private insurance in supplementing Medicare's coverage gaps; to evaluate the effectiveness of the States in regulating the sale of Medicare supplemental insurance; and lastly, to determine whether State and Federal regulatory agencies have done an effective job in eliminating the abusive marketing practices identified in earlier congressional investigations. Ultimately, the questions this report seeks to answer are: How effective has the 1980 reform legislation been in bringing about a reduction in abuse in the sale of supplemental insurance to the elderly? Do abuses persist?

The answers to these questions are immensely important as the Congress and the administration in coming months will be developing legislative proposals to insure Medicare's future solvency and improve its benefit package. As we look to the means for protecting Americans against bankruptcy health catastrophes like Alzheimer's and many forms of cancer—not covered by public or private insurance—we must scrutinze the adequacy and effectiveness of health insurance coverage currently available to our nation's older Americans.

In the course of conducting this inquiry, the subcommittee staff undertook the following steps:

At the chairman's request, prepared and sent to all State commissioners of insurance a detailed 11-page questionnaire designed to ascertain each State's experience in the regulation of Medicare supplemental insurance. Results from this February 1984 questionnaire have been tabulated and appear in section V of this report. The questionnaire itself is reprinted in its entirety in appendix A of this report.

At the chairman's request, prepared and sent to all State commissioners of insurance a 6-page questionnaire to update each State's experience in the regulation of Medicare supplemental insurance. Results from this March 1986 questionnaire have been tabulated and appear in section V of this report. The questionnaire itself is reprinted in its entirety in Appendix B of this report.

Conducted detailed followup telephone interviews with all State departments of insurance in 1983 and 1986.

Reviewed all hearings and reports on this subject by congressional committees and administrative agencies.

Reviewed all books, periodicals, and newspaper articles relating to Medicare supplemental insurance policies in the possession of the Library of Congress.

At the chairman's request, prepared and sent to 647 Area Agencies on Aging a 26-item questionnaire designed to meas-

ure the knowledge older people have about the basic attributes of health insurance. Each AAA was to administer the questionnaire to 1 senior center within their geographic reach, with no fewer than 20 senior citizen respondents. The results of this questionnaire were tabulated and appear in section II of this report. The questionnaire itself is reprinted in its entirety in appendix C of this report.

Recruited postal inspectors to assist the subcommittee staff as detailees in identifying fraudulent practices in the sale of insurance to supplement Medicare.

Asked every congressional office to save complaints received with respect to the operation of Medicare and private insurance for the month of July 1984. Literally hundreds of complaints were received from a quarter of all congressional offices. The complaints were analyzed and summarized in part and appear in section II of this report.

In order to determine firsthand if abuses in the sale of Medigap insurance policies are as frequent and widespread as this report suggests, the subcommittee staff interviewed a dozen insurance agents in Maryland, Virginia, and the District of Columbia. A senior citizen recruited by the subcommittee to serve as an interested insurance consumer was present at every sales presentation. In addition, a senior citizen recruited for the 1978 investigation was once again assigned to assist the subcommittee. The sales presentations were meant to test whether agents would engage in abusive sales techniques to make a sale. The senior citizen volunteers already had supplemental insurance. One was adequately insured, the other was overinsured. The results of the subcommittee's investigation are detailed in section IV of this report.

Discussed Medigap insurance abuses with participants in senior citizen centers in Maryland, Virginia, the District of Columbia, and Louisiana to ascertain their familiarity with their insurance coverage and its gaps. Our analysis of their perceptions is detailed in section II of this report.

Requested expert analysis of insurance advertisements and literature received by the subcommittee during the course of its inquiry. Solicitations were reviewed by experts with nationally recognized medical or scientific expertise in the specific line of insurance the ad was said to address.

Called upon the General Accounting Office (GAO) to undertake a review of all Medicare supplemental insurance policies promoted to cover the gaps in long-term care. This inquiry is a recent request and currently in progress. Therefore the results are not available for public distribution.

In 1978, the committee found that $1 out of every $4 spent on supplemental health insurance by the elderly was wasted—for a total of $1 billion. The subcommittee estimates that senior citizens will be taken for more than $3 billion in 1986, and that the amount of dollars lost will continue to escalate until corrective action is adopted.

Section 1 of this report documents the dramatic increase in the cost of health care since the enactment of the Medicare Program. In 1950, Americans spent $12 billion for health care. By the end of

1986, our Nation's annual expenditures for health will have increased a startling 3,535 percent to $424 billion, or an average of $1,723 per person. Expenditures for health care are expected to continue to grow rapidly, more than doubling by the year 2000 to over a staggering $1 trillion.

Increased health care costs impact disproportionately on older Americans who continue to be sick three times as often and three times as long as their under-65 counterparts. The elderly will pay nearly three times as much as younger adults for health care. In 1966, the year that Medicare went into effect, older Americans paid an average of $445 per capita for health care. In 1986, per capita expenditures for health care among the aged will average $4,601. In sum, elderly will pay one-third of the Nation's health care bill in 1986 totaling $131 billion.

The Medicare Program has been a godsend to our nation's 28 million elderly. Today, the program pays about 48 percent of the average older American's health costs. But in order to offset the ever escalating portion of the health bill not covered by the Medicare Program, seniors are increasingly purchasing private health insurance to supplement their Medicare coverage. Today, four of five senior citizens have insurance to supplement Medicare, often referred to as Medigap insurance. (About 10 percent of these senior citizens receive supplementation through the Medicaid Program.) Most have at least one such policy, many have more. This represents a 6-percent increase over 1978—the year the House Select Committee on Aging determined that about two-thirds of the elderly were in possession of Medigap policies. In all, the 21 million elderly who in 1986 own Medigap policies will pay an estimated cost of $13 billion, or more than $600 per person on the average. In return, private insurance will pay about 7 percent of the aged's health care bill, in contrast to Americans under the age of 65 who will pay about $112.4 billion for private health insurance and have approximately 86 percent of their health care bills paid for by private insurance.

In 1972, Blue Cross and Blue Shield provided 50.1 percent of all Medicare supplemental policies; independent plans accounted for 4 percent and commercial insurance companies received a 45.9 percent share of the Medigap marketplace. These figures have changed little over the last 13 years. Blue Cross garnered 45 percent of the Medigap market in 1985, followed by commercial insurance companies and other prepaid plans capturing about 55 percent.

As in 1978, the subcommittee found few problems associated with the sale of Medigap insurance by Blue Cross/Blue Shield or other companies selling group insurance to the elderly. The primary problems still relate to the operation of companies who specialize in the sale of Medigap insurance to the elderly on an individual basis.

Section II of the Report discusses the benefits of the Medicare Program, what it covers and what it does not cover. From the beginning of the Medicare Program, there remains a misunderstanding about the extent of Medicare's coverage. Partly, the result of wishful thinking and partly the result of the distribution of misleading publications which trumpeted Medicare's virtues, senior

citizens have been left with the impression that Medicare offers comprehensive coverage. In the years following Medicare's enactment, millions of senior citizens have had their illusions rudely shattered having been left with sizable bills which Medicare refuses to pay.

Escalating health care costs have resulted in older Americans actually paying more of their incomes for doctors, hospitals, drugs and long-term care than they did before Medicare was enacted in 1965. Other factors fueling increased health costs borne by elders include the implementation of the new prospective payment system for hospitals in 1983, resulting in a reduction in the number of days a senior citizen will stay in a hospital. This coupled with fewer doctors willing to accept what Medicare offers as full payment (7 out of 10 doctors accepted assignment in 1966, as compared to less than 1 out of 3 today), have both left seniors with a larger portion of their hospital and doctor's bills for which Medicare will not reimburse them.

Coupled with the aged's increased share of the health care bill for services covered by Medicare is the financial burden associated with services not covered by the Medicare Program, including out-of-hospital prescription drugs; eyeglasses and eye care; dentures and dental care; hearing aids and hearing care; custodial nursing home care; most food care; immunizations; and home care services, except under increasingly limited circumstances.

Section III notes that seniors, fearful of potential bankruptcy and loss of financial independence associated with a long, drawn out illness, are increasingly turning to the purchase of private insurance to supplement Medicare. Seventy percent have at least one such policy, many have three, four or more, mistakenly thinking that more is better. Section III describes the types of policies sold in supplementation of Medicare and the marketing methods most commonly used by the health insurance industry. The subcommittee found that the potential benefit from Medigap coverage has declined substantially since 1981, due largely to the imposition of the Medicare prospective payment system which has resulted in shorter hospital stays. Under the new system, older Americans are sent home sooner and for the most part Medigap policies stop paying when one leaves the hospital.

The subcommittee also found that the television is competing effectively with the salesmen as a marketing tool in the sale of insurance to older Americans. Well known personalities are extremely effective, the subcommittee discovered, in inducing thousands of seniors to buy the Medigap policy they endorse. Unfortunately, few elderly understand what Medicare or their private insurance covers, and therefore, are quite receptive to plans offered or promoted by well-known and trusted television personalities. The simple fact is that no policy covers all of Medicare's gaps, and few Americans, including the elderly, understand that fact. A 1986 survey by the subcommittee administered by the Area Agency on Aging directors to over 10,000 senior citizens nationwide underscored this sad truth. Nearly 80 percent of all seniors surveyed in 1980 believed that Medicare would pay for nursing home care should they need it—when in fact, 90 percent of nursing home care is rendered in custodial facilities which are not covered by Medi-

care or private insurance for the most part. The 1986 survey results reaffirmed this 1980 finding.

Section IV of the report reaffirms the 1978 committee finding that older Americans are frequently the targets of fraud and abuse in the sale of Medicare supplemental insurance; that such abuses are not isolated but occur nationwide, and that the incidence of abuse has not diminished but persists in spite of regulatory improvements at the State level. Section IV provides a chronology of Federal, State, local, and private efforts relating to abuses in the sale of Medicare supplemental insurance to the elderly; an analysis of responses from State commissioners of insurance confirming abuses in the sale of Medicare supplemental insurance to the elderly from 1978 to 1986; and a summary of investigations of the House Select Committee on Aging and its Subcommittee on Health and Long-Term Care confirming abuses in the sale of Medicare supplemental insurance to the elderly from 1978 to present day.

Who is responsible for regulating the health insurance industry and what has been done about curbing the increasing incidence of abuse in the sale of such insurance to the elderly? In part, the answer is that the States still retain near-exclusive authority to regulate the insurance industry since the Congress enacted the McCarran-Ferguson Act in 1945, stating essentially that no act of Congress, unless specifically relating to the business of insurance, shall be construed to invalidate, impair, or supercede any State laws regulating the business of insurance.

If the primary responsibility for regulating the sale of insurance rests with the States, the logical question section V of the report seeks to answer is, "How effective have the States been in their regulation of health insurance and more specifically of Medicare supplemental policies?" To determine the effectiveness of the States in monitoring abuses in the sale of Medigap insurance to the elderly, comprehensive questionnaires were prepared and sent by the subcommittee to all 50 State departments of insurance in 1984, and again in 1986. The questionnaire sought answers to questions regarding the State's budget and staff resources for insurance regulation, the dollar volume for all premiums paid for all kinds of insurance sold in their States, State laws in place to protect the public from misrepresentations in the sale of insurance, the number of agents licensed to sell insurance in each State, agent licensing requirements, disciplinary actions taken against agents and/or companies when it was determined that abuse did in fact occur, health insurance complaints received annually, the types of abuses brought to the attention of each State department of insurance, and their views on further regulatory reform necessary or desirable. The responses to these questionnaires were tabulated, analyzed and presented in section V of the report.

Section VI seeks to determine the effectiveness of those Federal agencies with regulatory authority relating to the sale of health insurance in the United States. This section reports on the activities and regulatory authority of the U.S. Postal Service, the Federal Trade Commission, the Department of Health and Human Services and the Justice Department in this regard.

Section VII provides the summary and conclusions of the subcommittee's investigation into abuses in the sale of health insur-

ance supplementing Medicare, and section VII provides policy recommendations that might be considered by State and Federal lawmakers.

I. THE NUMBERS

In 1950, Americans spent $12 billion for health care. By the end of 1986, our Nation's annual expenditures for health will have increased a startling 3,535 percent to $424.2 billion, or an average of $1,723 per person. Expenditures for health care are expected to continue to grow rapidly, more than doubling by the year 2000 to over a staggering $1 trillion.

It should come as no surprise to most Americans that health is the second largest and fastest growing industry in the United States today, accounting for about 11 percent of the gross national product.

Table 1 below shows subcommittee estimates of health care expenditures in 1986. Some $157.9 billion or 41 percent of the total was paid for hospital care, including both inpatient and outpatient care. The increased cost of hospital care has a significant impact on our Nation's elderly. Those persons aged 65 and over are two and a half times more likely to be hospitalized than persons under the age of 65, and their average length of stay is nearly twice that of other age groups.

The second largest category of health care expenditures is physicians' services, totalling $75.4 billion or 19.5 percent of the health care dollar. This catchall grouping includes the cost of all services and supplies provided in physicians' offices, expenditures for services by private practitioners in hospitals and other institutions, and diagnostic laboratory work in independent clinical laboratories ordered by physicians.

Dental services account for another 6.5 percent of total health spending. The estimated 1986 dollar amount for these expenditures will total $25.1 billion. Payments for drugs and medical sundries will total some $25.8, accounting for approximately 6.7 percent of the health dollar. An additional $35 billion or 8.3 percent of the 1986 budget will go toward payments for nursing home care.

As the percentages given below in table 1 illustrate, two-fifths of the health spending in 1986 was for health care services provided by hospitals:

TABLE 1.—1986 NATIONAL HEALTH CARE EXPENDITURES

[Dollar amounts in billions]

	Amount	Percent
Total	$424.2	100
Health services and supplies	406.9	
Personal health care	374.3	88.2
Hospital care	172.9	40.8
Physicians' services	82.5	19.5
Nursing home care	35.0	8.3
Drugs and medical sundries	28.3	6.7
Dentists' services	27.5	6.5
Other health services	10.3	2.4
Other professional services	9.6	2.3

TABLE 1.—1986 NATIONAL HEALTH CARE EXPENDITURES—Continued

[Dollar amounts in billions]

	Amount	Percent
Eyeglass and appliances	7.4	1.9
Program administration	20.9	
Government public health acts	11.7	
Research and construction of medical facilities	17.3	

Health care costs have a disproportionate impact on older Americans. During the intervening years from 1950 to the present, the Nation's elderly have continued to be sick three times as often and three times as long as their under-65 counterparts. The elderly also continue to pay nearly three times as much as younger adults for health care. In 1966, the year that Medicare went into effect, older Americans paid an average of $445 per capita for health care. Over the following two decades the elderly's health care costs have taken a quantum leap of some 1,100 percent. According to subcommittee estimates, in 1986, per capita expenditures for health care among the aged will average $4,601.

As detailed in table II below, older Americans' health care costs represent nearly one third of national expenditures in this area. According to subcommittee estimates, the elderly health care bill will total $131.3 billion in 1986, 30.3 percent of the national total of 424.2 billion. The largest percentage of elderly health care dollars goes for the payment of hospital care, with some $59.3 billion paid for such care in 1986. Nursing home care represents the second and fastest growing segment of the elderly's health care expenditures, reaching over $27 billion in 1986. The third largest category of elderly health care expenditures is physician services. The $27 billion spent in 1986 will account for 20.6 percent of the elderly health care budget. Other health services such as home health care and dental and eye care account for $17.5 billion or 13.3 percent of 1986 expenditures.

TABLE II.—1986 ELDERLY HEALTH CARE EXPENDITURES

[Dollar amounts in billions]

	Amount	Percent
Personal health care	131.3	100
Hospital care	59.3	45.2
Nursing home care	27.5	20.9
Physician's services	27.0	20.6
Other health services	17.5	13.3

The Medicare Program has helped seniors carry some of their heavy health care burden. Expenditures under this program for elderly health care will total an estimated $64.1 billion in 1986, covering 48 percent of older Americans' health costs. Seniors, however, are left with more than half of an ever increasing medical bill. The subcommittee estimates that in 1986 Americans will be forced to

spend an average of $1,700 out of their own pockets for the health care they require.

In order to offset the ever escalating cost of health care, senior citizens are increasingly purchasing private health insurance policies to supplement their Medicare coverage. Four of five seniors have at least one such policy, often referred to as Medigap coverage.[1] It is not uncommon for older Americans to purchase more than one such policy. In fact, a great many senior citizens are paying monthly premiums for as many as four or five policies; in some instances, they have purchased as many as 30 different policies in a desperate attempt to offset the bankrupting effect of a catastrophic illness.

In 1976, there were 17.1 million Medicare supplemental insurance policies in force, according to the Social Security Administration. By 1985, an estimated 28 million such policies were sold to the elderly and held by them.

Some 11 million older Americans paid an estimated $500 million for private supplemental health insurance in 1972. Today 21 million elderly own such policies at an annual estimated cost of $13 billion, more than $600 per person. They will receive an estimated $7.8 billion in benefits (60 percent of premiums paid), accounting for about 7 percent of their health care bill. The rebate to older Americans after purchase of health insurance bears a sharp contrast to that of Americans of all ages. All told, there are about 217 million Americans with some form of health insurance, or 86.6 percent of the population. They paid about $112.4 billion in premiums in 1983 and they received $96.6 billion or 86 percent of that back in benefits.

In 1972, Blue Cross and Blue Shield provided 50.1 percent of all Medicare supplemental policies; independent plans accounted for 4 percent and commercial insurance companies received a 45.9 share. The 45.9 percent represents a share of commercial insurance sales to the elderly and a 35-percent share representing policies sold to individual senior citizens. These figures changed very little over the past 12 years. Blue Cross/Blue Shield now garners 45 percent of the total. Commercial insurance companies and other prepaid plans receive 55 percent.

The subcommittee staff found few problems associated with the sale of Medicare supplemental insurance by Blue Cross/Blue Shield, by independent plans, or in the practices of commercial insurers who sell group insurance to the elderly. The primary problems related to the operation of companies which specialized in selling Medigap insurance to individuals. Moreover, as the staff soon discovered, the root or the problem lies with the limited coverage that Medicare provides and in the inability of many older Americans to understand what Medicare covers. Section II provides background on the Medicare Program necessary to understanding abuses in the sale of Medicare supplemental insurance.

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[1] Ten percent of those seniors receive supplementation through Medicaid.

II. MEDICARE AND ITS "GAPS"

The original mission of the Medicare Program when enacted by Congress in 1965, was a laudable one: to provide a coordinated approach for health insurance and medical care for the aged by establishing:

One: A basic plan providing protection against the costs of hospital and related care financed through a separate Federal payroll tax and a separate trust fund. This is the so-called part A of Medicare that will be referred to hereafter.

Two: A voluntary supplementary plan providing payments for physicians' services and other medical and health services financed through small monthly premiums by individual participants. This part became known as part B of Medicare which is further described below. In addition to premiums, part B is also financed by general revenues from the Federal Treasury.

While this is still Medicare's mission, the cost of the program has risen rapidly over the past 20 years; the cost of hospital and medical care has risen dramatically, and the elderly are paying more for their medical care today than they were before Medicare was enacted, without realizing an increase in the health services provided.

The spiralling cost of this increasingly nonprotective program and its impact on the Federal and aged person's budget has become a subject of increasing concern, and has far-reaching implications. It affects not only the present and future program beneficiaries, and the program itself, but potentially the entire Nation.

This section provides a basic description of the Medicare program. It outlines the growth and development of that program since its enactment in 1965. It also mentions briefly the Medicaid program which offers medical assistance to the poor. It identifies complaints and fears older Americans have with respect to the protection these programs offer, and discusses the forms of protection that have been devised and the forms of protection the elderly seek to curb their dissatisfaction and alleviate their fears concerning their anticipated health care needs.

MEDICARE—PART A

As noted above, part A is a basic plan to provide protection against the cost of hospital and related care. It is funded through a separate payroll tax and a separate trust fund. Some 98 percent of America's senior citizens are automatically eligible for this protection. In addition, a small number of individuals under age 65 who are disabled or who need kidney transplantation or dialysis are eligible. In fiscal year 1986, an estimated 31 million persons are covered under part A, the so-called hospital insurance portion of Medicare. The 2 percent of the Nation's elderly who are excluded are generally individuals who work in military or Government service who have a separate retirement system and thus have not paid the Medicare payroll tax or to social security in their working years. They may enroll in part A by paying the full actuarial cost of such coverage ($214 a month in 1986).

From 1967 to 1985 anywhere between 19 and 23 percent of the enrollees under Medicare part A have utilized hospital services each year.

Coverage under part A is based on the concept of a benefit period or spell of illness, a period which begins when an individual enters the hospital and ends when that individual has been out of the hospital or skilled nursing facility for 60 consecutive days. In each benefit period, individuals are entitled to 90 days of hospital care, home health visits, hospice care and, following a hospital stay, up to 100 days in a skilled nursing facility. If hospital benefits are exhausted in a spell of illness, Medicare allows the beneficiary to draw on an additional 60 lifetime reserve days.

As indicated in table III below, although part A is principally financed through a special hospital insurance payroll tax levied on employers, employees, and the self-employed and requires no premium payment, beneficiaries are liable for sharing in the cost of the health services they receive by meeting certain deductibles and coinsurance payments:

For the 1st through the 60th day of a hospital stay, Medicare pays for all covered services except for a first day deductible of $492.

From days 61 to 90 of a hospital stay part A pays for all covered services except for $123 a day. This is called the part A coinsurance.

Each of the 60 lifetime reserve days of the part A benefit is subject to a daily coinsurance of $246.

Part A of Medicare pays for all covered services received by a beneficiary in a skilled nursing facility for the first 20 days. The beneficiary is faced with a daily copayment of $61.50 for days 21 to 100 of such posthospital stay.

Beneficiaries are also fully liable for a deductible for the costs, or the replacement of the first three pints of blood.

Coinsurance and deductibles as outlined above are important concepts to remember, because these costs are generally all that is covered by most Medicare supplemental insurance policies.

TABLE III.—MEDICARE BENEFITS

Part A: Hospital Insurance Benefits

Coverage per "benefit period"	Beneficiary payments
A. Inpatient hospital service:	
First 60 days	$492.
61st to 90th days	$123/day.
60 lifetime reserve days	$246/day.
B. Skilled nursing facility services:	
First 20 days	None.
21st to 100th days	$61.50/day.
C. Home health care: Unlimited visits	None.
D. Hospice care: Have to be declared terminally ill	5 percent inpatient costs up to $492.
E. Blood	1st 3 pints.

MEDICARE—PART B

The Supplemental Medical Insurance Program (part B) is a voluntary program which provides older persons with protection against the costs of physicians' services, home health services, and numerous other medical and health services in and out of medical institutions. All persons age 65 and older who are eligible for Social Security benefits may elect to enroll in part B. An overwhelming majority, 97 percent, of Medicare part A beneficiaries maintain coverage under part B.

Those beneficiaries who elect to participate in Medicare part B must pay a monthly premium, equal to 25 percent of the program's costs, currently set at $15.50, or $186 a year. In addition, seniors must pay a deductible of $75. In other words, the elderly must pay the first $75 of their doctor's bill before Medicare will begin to help pay. Once the deductible is met, Medicare will pay 80 percent of what it determines are reasonable charges.

Part B of Medicare pays for 80 percent of reasonable charges for the following covered services: doctor's fees in or out of the hospital, home health visits (not subject to coinsurance), medical and related services, outpatient hospital services, and laboratory services. Radiology and pathology services provided by physicians to hospital inpatients are reimbursed without regard to the coinsurance and deductible requirements. If all of this is not complicated enough, payments for physicians' services are based on two other factors which go into the determination of what Medicare considers the reasonable charge. These factors are the customary charge and the prevailing charge.

The customary charge is the physician's median charge for a specific service or procedure in the previous year. For example, if your doctor has been charging patients from $1 to $30 for an office visit, his/her median or customary charge would be something around $15. One obvious point is that the use of this factor creates a disincentive for doctors to lower rates. In cutting fees the physician lowers his/her median charge and hence reduces what Medicare is likely to pay him/her in the following year.

The prevailing charge is the 75th percentile of what all doctors in a specified area charge for a specific service or procedure. For example, if doctors in Chicago are evenly distributed in charging from $1 to $30 for an office visit, the 75th percentile would be $22.50. This would be the Medicare prevailing rate.

Reasonable charge is defined by Medicare as the lowest between the following: (a) What the doctor charges the individual; (b) the doctor's customary charge; and (c) the prevailing charge in that area.

TABLE IV.—MEDICARE BENEFITS

Part B: Medical Insurance Benefits

	Coverage per "benefit period"	Beneficiary payments
A. Doctors services: services provided by: Doctors of medicine and osteopathy		(1) $75 annual deductible.

TABLE IV.—MEDICARE BENEFITS—Continued

Coverage per "benefit period"	Beneficiary payments
Dentists performing dental surgery	(2) Coinsurance of 20 percent of reasonable charge.
Podiatrists (excluding normal foot care)	
Chiropractors for treatment involving manual manipulatin of the spine to correct a subluxation..	(3) Any amount in excess of reasonable charge.
Optometrists for treatment of asphyxia	
B. Other medical and health services:	
Diagnostic x ray and lab tests	
Outpatient hospital and surgicial services	
X ray and other radiation therapy	
Outpatient mental health services	
Services and supplies furnished in connection with physician services	
Surgical dressings, splints, and casts	
Durable medical equipment	
Artificial devices that replace all or part of an internal body organ	
Ambulance services	
Braces and artificial legs, arms, and eyes	
Physical and speech therapy	
Rural health clinic services	

As stated above, Medicare part B pays 80 percent of reasonable charges. However, less than one third of all doctors providing Medicare services, accept assignment and agree to bill the Government directly for services they provide accepting as full payment what Medicare determines as reasonable charges. The rest, about 70 percent of Medicare doctors bill beneficiaries for more than the Medicare reasonable rate. As table V indicates, the assignment rate, the percentage of doctors accepting Medicare assignment, varies by medical specialty, from a high of 46.2 percent of nephrologists to a low of 23.6 percent among general practitioners (GP's). In the June 9, 1986 issue of Medical Economics, it was reported that:

The portion of physicians who agreed to accept Medicare reimbursement as payment in full dropped from 30.4 percent in fiscal 1985 to 28.4 percent this year—largely because of attempts to extend the (physician) fee freeze, HCFA says.

TABLE V.—PERCENT OF PHYSICIANS WHO ACCEPT ASSIGNMENT

	Percent		Percent
Nephrologists	46.2	Neurologists	33.2
Radiologists	39.5	Internists	31.1
Cardiologists	38.8	OBG's	30.5
Orthopedic surgeons	38.3	Urologists	29.0
Dermatologists	37.8	Psychiatrist	27.8
Pathologists	37 7	Family practitioners	27.1
General surgeons	34.5	Otolaryngologists	25.1
		General practitioners	23.6

A. Medicare 1986: Increasing costs of services covered by Medicare

Outlays for elderly health care benefits by the Medicare and Medicaid Programs amounted to $78 billion in 1985, or 23 percent of the $341 billion spent for personal health care. The Govern-

ment's share of the health care expenditures for the elderly has increased as a result of Medicare and Medicaid from 30 percent in 1966 to 62 percent of the total this year. But once again, the statistics may be misleading. The Medicaid Program—a Federal/State grant-in-aid welfare program, which is available to the poor of all ages—has increased dramatically while Medicare's share of the elderly's total health care bill has decreased.

In 1967, the first full year of Medicare, the plan covered 46 percent of the elderly's medical bills. By 1969, it paid almost 50 percent. Today, Medicare pays for only 48 percent of the average senior citizen's health care bills.

As illustrated in table VI, elderly Americans are actually paying more of their incomes for doctors, hospitals, drugs and long-term care than they did before Medicare was enacted in 1965. The subcommittee estimates that the average older American will spend 17 percent of his/her income on health care, up two percentage points of the pre-Medicare rate of 15 percent. According to subcommittee estimates, the average out-of-pocket health bill for seniors will top $1,700 in 1986, an increase of nearly 1,500 percent from the comparable 1966 figure of $110. Table VI also illustrates the failure of Medicare to provide protection for older Americans against the skyrocketing costs of health care in terms of total income. In 1966, before the full enactment of Medicare, seniors were spending 15 percent of their income on health care. Twenty years after the enactment of Medicare, the average older American has to spend more—some 17 percent or 2½ months of his/her income—on health care.

As table VII below illustrates, Medicare is paying a significant percentage (69 percent) of the elderly's hospital costs and a little more than half (59 percent) of their doctor bills. This program pays a negligible portion of the total bill for nursing home care (2 percent) and even less for prescription and over-the-counter drugs used by older Americans. The senior must then fill out the Medicare forms and seek repayment from Medicare for the 80 percent of the Medicare rate, leaving them fully responsible for the remaining 20 percent of the Medicare rate and 100 percent of their doctor's charge above that amount. For example, if a doctor who does not accept assignment, charges a Medicare beneficiary $100 for an office visit and Medicare determines the reasonable charge to be $50, Medicare will reimburse the beneficiary for only $40 (80 percent of $50) and the beneficiary would have to pay the remaining $60 of the bill out of his or her own pockets.

The natural question that arises is: Why are older Americans paying more and more for less and less protection from Medicare? The answer has many parts.

First, the elderly's share of costs for Medicare covered services has risen dramatically over the past 20 years. Medicare deductibles, coinsurance and premiums have skyrocketed since 1966, leaving seniors with higher and higher out-of-pocket costs. What follows is a summary of these cost sharing changes. Frighteningly, they are projected to continue to increase at a dramatic pace.

TABLE VI

Elderly Out-of-Pocket Health Care Costs:
The Impact of Medicare

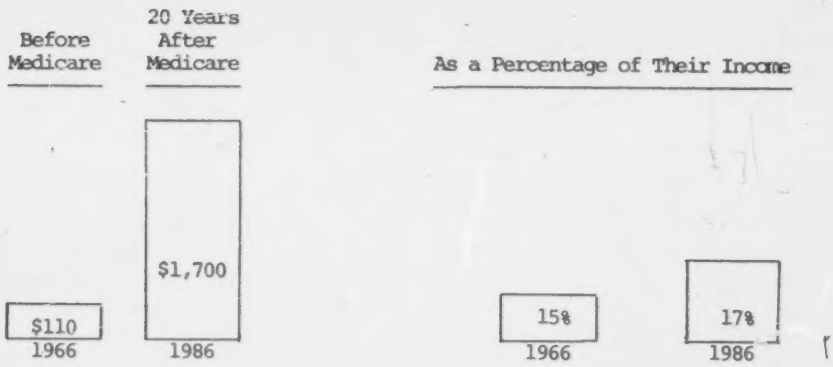
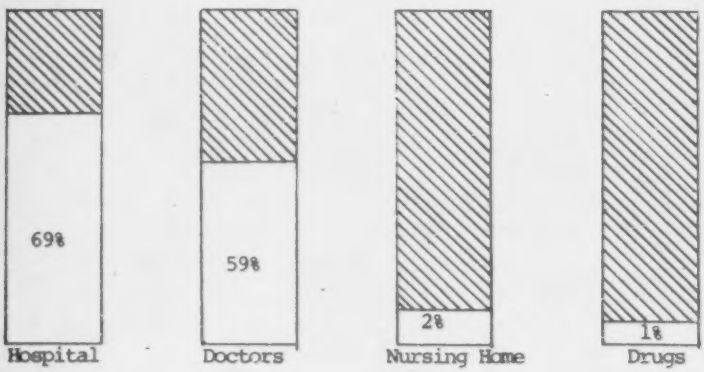


TABLE VII

What Medicare Pays: Percentage of Elderly Health Care Costs Covered By Medicare



Since the enactment of Medicare in 1966, the dollar amount for the part A hospital deductible has risen from $40 to $492. By 1991 it is predicted to reach $732.

Year:	*Rate*
1966	$40
1967	40
1968	40
1969	44
1970	52
1971	60
1972	68
1973	72
1974	84
1975	92
1976	104
1977	124
1978	144
1979	160
1980	180
1981	204
1982	260
1983	304
1984	356
1985	400
1986	492
1987[1]	572
1988[1]	616
1989[1]	648
1990[1]	688
1991[1]	732

[1] HCFA projections.

The hospital deductible is calculated on the basis of the average costs of hospital care provided Medicare patients per day. Because of this, since the 1984 imposition of the Medicare prospective payment system, the deductible has grown at a startling rate. Under the new payment system, Medicare pays hospitals a fixed amount per case based on the diagnosis of the patient treated. Unlike the old cost-based reimbursement system, the new payment method provides hospital strong incentives to get people out of hospital sooner. As a result, the average length of hospital stays paid for by Medicare has dropped from 9.5 in 1983 to 7.5 today. While overall Medicare hospital costs per stay have decreased slightly under this system, the average costs per day of care have risen sharply. The result of this has been an increase in part A hospital deductible from $304 in 1983 to $492 today. Further leaps in the deductible are predicted. By 1991, it is expected to reach a whopping $732!

The part A coinsurance rates for long hospital and skilled nursing facility stays are calculated based on the above detailed part A deductible. Accordingly, these rates have jumped dramatically over the past 20 years as well. The hospital coinsurance for days 61 to 90 in a hospital has risen from $10 to $123. The coinsurance for the 60 additional lifetime reserve hospital days has risen from $20 to $246. The coinsurance for the 21st through 10th day in a skilled nursing facility (SNF) has risen from $5 to $61.50 a day. As shown below, these costs are expected to nearly double again by 1991.

Year	Hospital days 61 to 90	Hospital reserve	SNF days 21 to 100
1966	$10	$20	$5.00
1967	10	20	5.00
1968	10	20	5.00
1969	11	22	5.50
1970	13	26	6.50
1971	15	30	7.50
1972	17	34	8.50
1973	18	36	9.00
1974	21	42	10.50
1975	23	46	11.50
1976	26	52	13.00
1977	31	62	15.50
1978	36	72	18.00
1979	40	80	20.00
1980	45	90	22.50
1981	51	102	25.50
1982	65	130	32.50
1983	76	152	38.00
1984	89	178	44.50
1985	100	200	50.00
1986	123	246	61.50
1987[1]	143	286	71.50
1988[1]	154	308	77.00
1989[1]	162	324	81.00
1990[1]	172	344	86.00
1991[1]	183	366	91.50

[1] HCFA projections.

The premium for medical insurance, Medicare part B, has risen from $3 to $15.50 a month:

Year	Rate	Year	Rate
1966	$3.00	1979	$8.70
1967	3.00	1980	9.60
1968	3.00	1981	11.00
1969	4.00	1982	12.20
1970	4.00	1983	12.20
1971	5.30	1984	14.60
1972	5.60	1985	15.50
1973	5.80	1986	15.50
1974	6.30	[1]1987	17.80
1975	6.70	[1]1988	18.50
1976	6.70	[1]1989	19.30
1977	7.70	[1]1990	20.00
1978	8.20	[1]1991	20.70

[1] HCFA projections.

As indicated by the charts above, the hospital deductibles and coinsurance have increased over 1,200 percent since the inception of Medicare. The part B monthly premium for physicians's service has jumped 517 percent.

Second, central to any discussion of the older person's increased health care bill is physican fees. In 1984, Medicare paid for only 58 percent of physican fees, which account for 21 percent of the elderly's total health care expenses. The decline in Medicare's share of expenses for physician services has resulted partly from the increase in the deductible for part B from $50 to $60 to $75 in 1983. More importantly, however, is the fact that many doctors now

choose not to accept the Medicare reasonable rate and that the difference between this rate and what is actually billed by these nonparticipating doctors is increasingly steadily, saddling the elderly with larger and larger out-of-pocket costs.

Congress has frozen Medicare reimbursement for doctor services since 1984 and long delays (often as long as 4 to 6 months) in the processing of claims by the Medicare carriers have gotten worse in recent months because of administration attempts to save money by slowing down paying the Government's bills. Congress has tried to provide incentives for Medicare assignment by promising quicker claims processing and full payment increases to those doctors who agree to accept assignment for all their Medicare claims. While this has resulted in a slight improvement in the national assignment rate, much of these efforts have been counteracted by failure to speed up claims processing and increasing costs of medical practice.

The more than two-thirds of physicians not accepting Medicare assignment have steadily increased their bills, outpacing increases in Medicare reasonable charges, and leaving the elderly to foot a larger and larger portion of their doctor bills. In 1975, the average difference between the Medicare reasonable charge and the amount billed patients by physican not accepting Medicare assignment as 16.7 percent. In other words, an average physican not accepting assignment would have billed $116.70 for a procedure or service Medicare would have determined to reasonably be worth $100. By 1984 the average discrepency between bills and Medicare rates had increased to 23.6 percent, meaning that Medicare is actually paying for no more than 65 percent of nonassigned doctor bills. For example, take a bill for $124 from a doctor not accepting assignment. If this was an average bill in 1984, Medicare would have deemed the reasonable charge to be $100 and pay $80 (80 percent), leaving the beneficairy to pay $44 of the $124, fully 35 percent of the total bill. If the doctor in this example did accept Medicare assignment, the beneficiary would have had to pay $20, 20 percent of the Medicare reasonable charge.

A third factor adding to the health costs of, and eroding the quality of care provided to, the elderly has been the increasing number of retroactive payment denials by the Health Care Financing Administration, the Federal agency charged with administering Medicare. The subcommittee held a hearing in Jefferson City, MO in March of 1985 to examine the nature and extent of such denials. It was learned that many seniors are having vitally needed care refused, sometimes saddling them with huge medical bills, sometimes resulting in pain, suffering and even death. Dr. David Voshall told the subcommitte of one such case:

> J.K. was an elderly white male who presented himself in the (doctor's) office. He was known to have coronary artery disease. He had recently been hospitalized for epigastric pain and found to have gall bladder disease. When he came to the office on October 4, 1984, he was complaining of nausea, abdominal pain, and chest pain * * * His admission (to the hospital) was denied. I recommended that

J.K. go into the hospital. He refused. The next morning he died at home of cardiac arrest.

It was also revealed at this hearing that many of the Peer Review Organizations (PRO's), the independent physician group employed by Medicare to review the care provided in hospitals to Medicare patients, had stipulated in their contracts the objective of reducing hospital admissions by significant amounts. In the case of Missouri, the PRO's contract called for a statewide reduction of 65,328 hospital admissions, a cut of some 10 percent of the total. These reductions have several impacts. First, they may indeed eliminate some unnecessary services being provided to Medicare beneficiaries. Second, if improperly made, they may deny access to needed care such as in the example above. This may happen either by a denial by the PRO or a denial of admission to the hospital, which, based upon past denials, fears that it may not be paid by Medicare if the patient is admitted.

Retroactive denials of payment for Medicare-covered services have not been limited to hospital care. The subcommittee has received hundreds of letters and phone calls from across the nation detailing technical denials of care and payment for care by Medicare and the officials which administer it. In what Medicare officials call "tightening" of controls on the use of skilled nursing facilities and home health care, millions of older Americans are denied the care they desperately need. This comes at a time when demand for these services is skyrocketing because of the proclivity of hospitals to discharge hospital patients sooner and sicker under the new Medicare prospective payment system. The following section contains a number of glaring examples of these benefit cutbacks.

The common denominator of all these factors is cost. The cost of hospital care has increased dramatically, as has the cost of physician care. As noted, the increases in the cost of health care have outpaced increases in the cost of living and elderly income by a wide margin. As costs have risen, the levels of coinsurance amounts and deductibles have also increased. Since these increasing costs have already placed a considerable strain on the Medicare Trust Fund, Congress has been reluctant to increase benefits. Congress has had to fight off continuous attempts by this administration to increase costs borne by the elderly and to decrease services.

To the elderly, all of this means that they are on a kind of health care merry-go-round which never stops—instead it gradually picks up speed every year. In addition to having to pay more to participate in Medicare and finding Medicare will pay less and less of their health bills, the elderly have been confronted with escalating costs of health care services which they vitally need but for which Medicare does not provide coverage.

B. Increasing costs and the increasing need of services not covered by Medicare

Coupled with older Americans' increased share of the health care bill for the services covered by Medicare is the financial burden associated with necessary health services often not covered by the program.

Medicare explicitly excludes from coverage an array of important services used by the elderly. These include:

Drugs which can be self administered.—People over 65 represent 12 percent of the population, yet they take about 30 percent of prescription drugs. On the average, seniors use some 13 prescriptions per person per year. Seventy percent of the elderly use over-the-counter drugs, compared to about 10 percent of the general adult population. Although drugs and sundries are needed by such a large number of older citizens, Medicare pays nothing. Medicaid pays about 6 percent (for impoverished elderly), but pays nothing for over-the-counter drugs. The bulk of the elderly's annual drug bill—some $10 billion annually—must be paid out of their own meager incomes. Payments for drugs represent up to 20 percent of the elderly's total out-of-pocket health care costs—$340 per person per year.

Dental care.—Dental problems such as tooth decay and periodontal disease are so widespread among the elderly that half of all persons over 65 have no natural teeth; almost 1 in 10 of those elderly persons without natural teeth also have no dentures. Medicare pays for no dental care except very selective forms of dental surgery. It does not pay for regular dental care or dentures. As of 1983, Medicaid programs in 44 States offered dental services and 37 provided some coverage for dentures. Dental services account for about 2 percent of the elderly's health care expenses.

Eyeglasses or eye examinations.—Nine out of ten, or 26 million older Americans require and own eyeglasses. However, 1 in 5, or over 5 million of these seniors are wearing glasses which need replacement or correction. Medicare pays nothing of the costs of eyeglasses or related care. It does not pay for routine tests which may prevent more serious vision problems. In 1983, 46 State Medicare programs offered coverage of eyeglasses for indigent residents.

Hearing care or examinations.—One in three persons over age 65 suffers from impaired hearing. For 8 percent of the elderly, the problem is so severe that they are unable to hear words spoken in a normal voice. An estimated 10 percent, or 2.8 million elderly use hearings aids which cost from $200 to $1,000. Medicare does not pay for hearing aids or routine hearing care.

Custodial nursing home care.—Nursing home care is the second largest and fastest growing personal health care expenditure by older Americans, amounting to $32 billion, or nearly $1,200 per capita in 1986. Expenditures for the 5 percent of the elderly in nursing homes are obviously much higher, from $20,000 to $40,000 a year. Medicare pays virtually nothing—just a little more than 1 percent of the costs for those 1.4 million elderly Americans confined to nursing homes. The reason for that is that Medicare does not pay for custodial care for the elderly in their own homes or in nursing homes. Medicare will only help to cover the costs of skilled nursing care after a hospital stay of 3 days. In addition, the skilled nursing facility care must be prescribed by a doctor, be required for care for a condition which was treated in the hospital, and be

approved by the facility's utilization review committee or a peer review organization. The vast majority of nursing home care required by older Americans is for a number of chronic, long-term impairments and does not meet the Medicare definition of skilled care. Therefore, those in need are required to carry the tremendous costs of such care on their own. Half of nursing home admissions are attributable to Alzheimer's disease, the dastardly, degenerative organic brain disease which robs up to 4 million Americans of mind and ultimately body. Medicare pays nothing for the care and treatment of Alzheimer's disease victims. As a result of the absence of any assistance from Medicare for this expensive care, most seniors are quickly impoverished after entering a nursing home. It is only after one has spent all of his or her money and sold most assets that he or she may get any government assistance—from Medicaid, the Federal/State welfare program. Medicaid pays for approximately 45 percent of nursing home costs.

Home health care.—Home health care services are covered by Medicare only when a very limiting set of criteria are met. To receive home health care, a Medicare beneficiary must demonstrate he or she is homebound, and that the care needed: (1) includes skilled nursing care, physical therapy, or speech therapy; (2) is part time or intermittent; (3) is prescribed in a plan or care by a physician; (4) is provided by a Medicare-certified home health agency. Because of these very restrictive eligibility criteria and Medicare's even more restrictive interpretation of them, an estimated 5 million Americans today go without the home care they need. It is estimated that nearly half of the 1.4 million elderly in nursing homes could be cared for at lower cost and with better quality in their own homes if proper care was available. Thousands more must receive needed care in the hospital when less expensive care could be provided in the home, imperiling their lives and unnecessarily wasting millions of Medicare dollars.

In March of 1986, the second in a series of hearings on catastrophic health insurance was held by the subcommittee in Washington, DC. This hearing focused on "Catastrophic Health Insurance: The Home Care Benefit." A panel of Americans, young and old, gave testimony about their personal problems trying to obtain vitally needed home care.

Ms. Randy Kramer of Miami, FL is a victim of cystic fibrosis whose survival depends on twice daily respiratory therapy to clear her lungs. She told the subcommittee: ". . . I am just one person speaking for the 47 million victims of chronic lung disease. . . . Medicare says that in order to receive home care I must be homebound. Even when I am homebound, Medicare will only pay for a physical therapist or a skilled nurse. This forces me to use the outpatient department of the Baptist Hospital for my treatment. The cost of these treatments is $190 a day. The cost of the same treatment at home is $60 a day. The Government can save a lot of money by letting me have my therapy at home. It would be better for me because every time I go to the hospital I am exposed to sickness that could cause readmission to the hospital. I am burning up my Social Securi-

ty money on travel (to the hospital) and it is also wear and tear on my body."

The subcommittee's report, "The Attempted Dismantling of the Medicare Home Health Care Benefit," released at this March 19, 1986, hearing, details the actions taken by the Department of Health and Human Services and its fiscal intermediaries cutting the home health benefit. The report contains glaring examples of the denial of needed home health care to Medicare beneficiaries. Included among these cases are the following:

Mr. S. received daily visits for 2 weeks for treatment of open wounds in the groin area. During the third week, (Medicare) disallowed two of five visits despite documentation of continued open areas with purulent drainage. The patient was unable to reach these areas for dressing changes and no one else was available to provide the care. Medicare declared the two visits not reasonable and necessary.

Mrs. P. was a 90-year-old woman with terminal cancer. Her family wanted to keep her at home with the assistance of the home health agency. Mrs. P. suffered from constant diarrhea, resulting in electrolyte imbalance, dehydration, and skin breakdown. Her condition was further complicatd by heart disease. Medication management was a problem for both Mrs. P. and her family. Medicare benefits were denied because (Medicare said) Mrs. P. did not need intermittent care. She died 2 weeks later.

Mr. L. was a 76-year-old in frail condition. He was bedbound with a diagnosis of pneumonia, chronic obstructive pulmonary disease, rib fractures, and flail chest. His doctor stated that daily intermittent positive pressure breathing treatments were needed due to Mr. L.'s severely compromised respiratory system. However, Medicare denied the daily treatments for 2 weeks, deeming them not medically necessary. Mr. L.'s frail and elderly wife could not carry out the treatments alone, however.

Mrs. P., a blind, diabetic double amputee, went to renal dialysis three times weekly. Her husband carried her to the car. She was declared not homebound.

Mrs. K. was confined to a wheelchair because of a stroke. She was unable to care for herself at all. Her elderly husband managed to get Mrs. K. to physical therapy three times a week under the orders of her physician, who thought there was a possibility for some rehabilitation. (Medicare) said that because Mrs. K. went to therapy three times weekly instead of two, she was not homebound. All of her skilled nursing and home health aide visits were denied.

Routine physical examinations.—Medicare and Medicaid do not provide coverage for physical checkups which in many cases detect developing disabilities in their early stages. Less than a million Medicare beneficiaries have elected to receive their health care through health maintenance organizations (HMO's). HMO's do offer preventive physician visits as a regular benefit.

Immunizations;

Most foot care;

Homemaker services and meals at home; and

Treatment outside the United States.

This abbreviated list of noncovered services is testimony to the narrow, acute care view Medicare has regarding the care elderly patients need. Unfortunately, Medicare, the program that was supposed to give older people a hedge against the overwhelming cost of health care, denies reimbursement for much of the services elderly people need the most.

C. Medicare: Beneficiaries' assessments

The subcommittee recently contacted each Member of Congress requesting that all constituent corespondence received in a recent month outlining difficulties encountered in the Medicare Program be forwarded to the subcommittee for review. Thousands of letters poured in detailing the frustration of growing old without the health care protection anticipated from the Medicare Program.

The testimonials of poor care, denial of care, abuse, deception, confusion and fear which unfold throughout the pages of these letters would open the eyes of even the most myopic to the inadequacies of our present health insurance programs. From elderly across the Nation we have learned that the health services needed the most are not covered by Medicare, and that many elderly are literally forced into poverty to obtain these costly, noncovered services. The letters revealed the tremendous fears older Americans have of not being able to afford the health care they need, as well as their anger at repeated attempts by this administration to cut Medicare benefits and increase their share of the costs. Excerpts from some of these letters follow:

I started on Social Security when it began in 1937 and paid into it ever since. Everyone thought it would give peace of mind when they retired or became too ill to work any more. Now I hear there are proposals to cut down on Social Security and Medicare—thanks a lot. It seems we elect officials to go to Washington to cut our throats. Why is it a man makes promises he never intends to keep?

R.P., *Los Angeles.*

A lot of older people cannot afford medical care, even with Medicare, because they can't pay the extra costs. We cannot, so we go untreated.

E.R., *Pembroke, Pines, FL.*

Why are the payments for Medicare becoming so expensive and the cost of living raise doesn't compensate for the increase? Our Government keeps raising our premiums and then turns around and cuts our benefits twice as much.

Y.K., Arizona.

Errors, long delays, indifferent cooperation, and unjustified denials of claims have made the Medicare Part B reimbursement program a horrendous nightmare. Confusion and inefficiency surrounding this process is not ony frustrating, but appears to be almost calculated to discourage our elderly citizens from seeking necessary medical attention. It could be a national scandal; it deserves immediate Congressional investigation. In several instances I have been forced to resubmit claims as often as three times. Enclosed is a copy of the surgeon's bill filed with Medicare Part B in December of last year in the amount of $3,083 for which I have received to date the some of $402.80 after three trips to the doctors' office, plus several phone calls to Medicare.

E.P., *Sarasota, FL.*

Since Medicare pays such a small share of the cost to the physician, why is he allowed to increase his fee and when the Medicare patient must pay more to the doctor to make up for what Medicare does not pay him? $45.00 for an office visit is ridiculous when the doctor spends 5 minutes with you.

I'm afraid some will try to turn Medicare into a welfare type program to cut the patient's hospital care. Please do what you can to stop them.

D.D., *Hampton, VA.*

It now takes 6 months to get Medicare bills (even those paid in advance) processed and claims for my 93 year old mother. She would never collect if she did not have someone to help her. It's disgusting.

B.C., *Miami, FL.*

The elderly don't want a government freebie. What we want is comprehensive health care at an affordable price.

F.M., *Bronx, NY.*

I'm concerned with the runaway costs. The reason I didn't retire earlier was that I was more concerned with keeping my company's medical plan and not relying on Medicare which I feel will be bankrupt the way its going. I was in the hospital for a total of 4 days. No surgery—just tests. The total cost was over $5,900 and even with two insurances it looks as if I will be stuck for over $1,500 because of deductibles and all.

ANONYMOUS.

My husband is a patient in a nursing home and can get no assistance because of his illness is diagnosed as Alzheimer's disease. Why can't Medicare help in any way. It is very costly and I don't know how much longer we can pay the bills.

M.S., *Atlanta, GA.*

I'm on Medicare. It wouldn't be so expensive it doctors were not given the right to legal robbery by overcharging. My doctor told me, "What do you care what I charge. It's covered by Medicare.

B.M., *New York.*

I am a widow and live on my Social Security check of $391 a month. I simply cannot afford an increase in Medicare. After I pay rent, food, insurance, eye doctor and family doctor, if an emergency comes along I have nothing left.

L.C., *Texas.*

I paid taxes all my life. I was refused entrance into hospital recently because I had no Medi-Cal. I am 73, and I am in need.

ANONYMOUS.

The prescription medication for my wife and I alone amounted to more than $1,000 in 1983, which exceeded 10 percent of our income. Medicare doesn't even consider these bill.

P.M., *Kansas.*

I carry Medicare and Blue Cross/Blue Shield but during last year I paid out of pocket over $10,000 for doctors, hospitals, and nursing home costs.

J.S., *Bradenton, FL.*

I recently lost my husband of 44 years after a long period of severe heart disease. The medical bill after 2 months of intensive care, and many weeks of recuperation after 2 strokes and the drugs are astronomical. Medicare is totally inadequate and we just were never able to save. So after his death I am faced with a devastating problem.

ANONYMOUS, *Vermont.*

Something must be done about the catastrophic cost of long term health care. My 85-year-old husband suffering from Parkinson's disease fell and broke his hip. He had to go to a nursing home. Nobody provides skilled nursing care at home. Medicare and medicaid cut that benefit years ago. He wants to come home. He's very unhappy in the nursing home. In 1 month he lost 16 pounds.

K.S., *Florida.*

My husband has Alzheimer's disease. Since I could no longer take care of him, I've admitted him to a nursing home. Medicare will not pay any of the cost. The financial burden ($20,000 yearly) is tremendous. I don't know where to turn.

N.K.

The preceding sections indicate that seniors have a well founded concern of Medicare's ability to protect them against skyrocketing health case costs. They are fearful of having to forego care when they need the most because of depleted financial resources. Projections are that Medicare will cover less and less of older American's fast growing health care bill. To many elderly, the bottom line to this is that they must look elsewhere for health protection. There are but two alternatives: Medicaid and private insurance.

MEDICAID

Medicaid is a Federal/State grant in aid program in which the Federal Government pays at least 50 percent of the costs incurred by the States paying for medical assistance to low income residents. Unlike the Medicare Program, Medicaid is not available to all senior citizens—only those who meet very strict income and asset requirements. To be eligible for Medicaid, a welfare program, in most States seniors have to have incomes well below the poverty level and have little to no assets.

Because many elderly have incomes which place them at or near the poverty level many are eligible for Medicaid benefits. In 1985, an estimated 12 percent persons over 65 will receive benefits under the Medicaid Program.

For many seniors, accepting Medicaid's benefits is a last resort. Seniors fear going on welfare. There is a tremendous psychological trauma associated with the acceptance of such moneys and most older Americans avoid it if they can. This trauma is understandable because the elderly must first give up their homes and lifetime savings before they can qualify for Medicaid.

The Medicaid Program provides coverage for inpatient hospital services, physician services, (whether furnished in the office, the patient's home, a hospital, or a nursing home), skilled nursing facility services, intermediate care facility services, skilled home nursing services, and laboratory and x-ray services. Other items or medical services can be provided at the option of the States.

The Medicaid law provides that no deductible, cost-sharing, or similar charge can be imposed by the State for hospitalization under its program and that such a charge on other medical services must be reasonably related to the recipient's income or resources. In addition, the Medicaid Program requires that elderly needy recipients under the State program must be provided assistance to meet the deductibles imposed by Medicare Part A.

The first experience most seniors have with Medicaid is when they need nursing home care. Expenditures for nursing home care are far and away the largest and fastest growing component of the Medicaid budget, accounting for 55 percent of the total budget in 1985. What typically happens is that seniors enter nursing homes paying the bills completely out of their own pockets. As mentioned earlier, Medicare pays for virtually no nursing home care. Seniors soon exhaust all of their own money because the cost of an average nursing home stay is more than $2,000 a month. After turning to family and friends and exhausting any help available there, the elderly, now destitute, are forced to apply for medical assistance through Medicaid.

Most of America's senior citizens, having grown up with the work ethic and priding themselves on their independence and self-sufficiency, will do almost anything rather than end up on the Medicaid roles as a Medicaid patient.

A last alternative is the purchase of private insurance to supplement Medicare.

III. FILLING THE "GAPS": MEDICARE SUPPLEMENTAL INSURANCE

Observing that Medicare continues to pay a smaller proportion of their ever escalating health care costs and out of fear of potential bankruptcy and loss of financial independence, more than ever older Americans are turning to the purchase of private supplemental health insurance. At the present time, the subcommittee estimates that up to 80 percent,[2] or an estimated 22.4 million out of America's 28 million citizens age 65 and older, have at least one health insurance policy in supplementation of Medicare. This represents an increase of nearly one-fifth in the percentage of older Americans with such insurance for an increase of some 7.4 million privately insured seniors since the committee issued its landmark study in 1978. Many seniors (an estimated 30 percent) have purchased up to 30 different policies without realizing that Medicare supplemental policies generally include a coordination of benefits clause which means that in areas of overlap only one policy will pay benefits.

Medigap insurance, even to the trained expert, is complex and often confusing. There are many different types of insurance and countless specific variations from policy to policy. It is very difficult for seniors to discern exactly what they are getting when they purchased a Medigap policy. It is very difficult to the consumer to determine the worth of the product reading the insurance policies in question. There is very often little information available to older Americans to assist them in purchasing Medigap. Thus, there is almost no opportunity to comparison shop. For most seniors the purchase of insurance is a reflex action; motivated by fear, they buy hope.

A. Types of Medigap policies

Medigap policies fall into the category of health insurance policies, also known as accident and health or disability policies. The terms are used synonymously in this report. There are four general types of policies which fall under the heading of Medigap:

(1) *Service benefit.*—This is the most common and widely known type of Medigap insurance. Service benefit policies generally provide coverage for a percentage of the Medicare coinsurance and deductibles. (See section II of this report for details on coinsurance and deductibles.) These policies, as their name implies, pay benefits based on the cost of medical services rendered to the beneficiary. Service benefit policies typically provide no protection against the costs of drugs, custodial nursing home care, private duty nursing care, dental care, eye care and hearing care.

Under model State regulatory standards developed in 1981 by the National Association of Insurance Commissioners (now utilized by 46 States), service benefit policies must cover:

The Medicare Part A hospital copayment for days 61–90 of a hospital stay;

The part A copayment for lieftime reserve days of hospital care; and

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[2] Ten percent of these seniors receive supplementation through Medicaid.

Ninety percent of hospital expenses for 365 days after Medicare benefits are exhausted.

The number of those who might potentially benefit from this coverage has, however, declined sharply since 1981. Since the imposition of the Medicare prospective payment system, the average length of Medicare hospital stays has decreased from 9.5 to 7.5 days. Part of the reason for this decrease is the sharp drop in the number of very long hospital stays. As table VIII below illustrates, the number of Medicare patients in the hospital longer than 60 days has dropped from very small to almost negligible. Specifically, whereas in 1981, some 3 percent of hospital visits for Medicare patients lasted longer than 60 days, in 1984 that number had dropped sixfold to one-half of 1 percent. The percentage of cases 90 days or longer has dropped over the same time from 0.7 percent of 0.16 percent. The number of stays 120 days and longer has fallen from 0.02 percent to 0.0017 percent. In other words, in 1984, the likelihood for a Medicare beneficiary to find him or herself in a hospital longer than 60 days was 1 in 1,428. The odds of a Medicare beneficiary being hospitalized longer than 90 days was 1 in 5,000. Those requiring hospital stays longer than 120 days totalled only 56 nationwide in 1984, making the odds of needing coverage 1 in about 500,000.

TABLE VIII.—LENGTHY HOSPITAL STAYS PAID FOR BY MEDICARE (1984)

Length of stay	Percent of total cases		Odds for all 65 and older	
	1981	1984	1981	1984
60 days of more	3	0.5	1/250	1/1,428
90 days of more	0.7	.16	1/1,000	1/5,000
120 days of more	.02	.0017	1/35,000	1/500,000

Under the NAIC Model Standards, service benefit policies are also requried to cover at least 20 percent of Medicare-approved charges for part B medical expenses. This means that they need not provide protection against the total actually billed the beneficiary. As discussed in section II, if a doctor does not accept the Medicare rate as payment in full, the typical service benefit policy provides no coverage against the amount billed above and beyond what Medicare finds reasonable. For example, a 72-year-old woman with a standard policy is billed by her doctor $100 for an office visit. Medicare then determines that the reasonable charge for the visit is not $100, but $60, and pays the woman 80 percent of that $60—$48. Her Medigap policy would pay her $12 (20 percent of the Medicare-approved charge), leaving the woman to pay the remaining $40 out of her own pocket.

(2) *Hospital indemnity.*—These Medigap policies, on the other hand, pay a flat stated number of dollars per day of Medicare-approved hospitalizations. This type of policy pays benefits only if the insured is hospitalized, and as such provides no protection against large medical bills not associated with a hospital stay. Also, because hospital indemnity policies pay a fixed amount, their worth is eaten away over time by inflation. These policies may also contain restrictions on when benefits will begin and the maximum

amount the policy will pay per day of illness. For example, a policy may pay $100 a day in a hospital, but will pay only if the policyholder has been in the hospital longer than 60 days and will pay a maximum of $5,000 per spell of illness. Because the odds of being hospitalized longer than 60 days is very small and continually shrinking, this policy may be of limited value to the average older American. On the positive side, many such hospital indemnity policies are less expensive than service benefit policies and pay benefits even if another policy is paying.

Many consumer advocates and State and Federal officials advise against the purchase of this type of Medigap policy. In their June 1984 issue, Consumer Reports stated:

> Hospital indemnity policies are widely advertised, often endorsed by celebrities. They are easy to understand. Compared to most health insurance, they are cheap. None of that, in CU's opinion, is reason enough to buy one.

(3) *Dread disease.*—These Medigap policies insure against only specific diseases. The preponderance of these policies are cancer policies, but others include insurance against other dread diseases such as leukemia, spinal meningitis, rabies, polio and the like. They provide very narrow coverage and only provide benefits if one gets the specific disease the policy covers. Although these policies are not typically offered to the elderly exclusively, many such dread disease policies are purchased by older Americans. However, many of these policies duplicate Medicare coverage. In its landmark 1981 report, "Cancer Insurance: Exploiting Fear For Profit," the committee documented many problems associated with the sale and purchase of dread disease policies.

(4) *Long-term care (nursing home) indemnity.*—There have historically beei relatively few insurance policies which cover the majority of expenses associated with long-term care. The same holds true today, but very recently there has been a considerable increase in interest among many insurance companies in developing such policies. A substantial amount of growth in the market for long-term care, care insurance is expected as the number of Americans needing such care skyrockets into the next century.

Of the limited number of long-term care policies available today, the vast majority are of the indemnity type and have very strict criteria for determining eligibility for benefits. Many will pay a fixed amount (typically considerably less than the total cost) per day of skilled nursing facility care certified by Medicare. This coverage often duplicates that offered by standard service benefit Medigap policies. Other long-term care policies offer a fixed amount per day of care in an intermediate or custodial nursing home, but only after a hospital stay or skilled nursing facility stay. Some of these policies do not pay benefits until the holder has been institutionalized for a year. This might easily leave one holding such a policy footing a bill of $20,000 to $40,000 before getting any assistance. Many long-term care policies limit benefits to stays of 3 years. Since 1 of 5 of those requiring nursing home care stay for 5 years or more, these policies may not alleviate the pauperization of the policyholder and comprehensiveness of coverage. Costs of policies range from $20 to $300 a month.

Long-term care indemnity policies currently offered typically exclude certain major illnesses such as Alzheimer's disease from coverage which accounts for about 50 percent of all custodial nursing home admissions.

The irony of all this is, of course, that senior citizens generally have purchased Medicare supplementary policies with the hope and expectation that it will cover all of the medical expenses for which Medicare will not pay. Insurance agents often represent to their prospective customer: "This policy will pay for everything Medicare doesn't cover." The reality is that most Medigap policies exclude from coverage all items not covered by Medicare.

It is understandable then why the elderly have been disappointed in the Medigap policies in the past and why they will continue to be disappointed in the future. Those who will be the most disappointed are those who have purchased several policies only to learn that the aggregate will not provide them with the health security they seek.

This is not to suggest that all Medicare supplementary policies are worthless, but only that their benefits are often exaggerated. Most experts would agree that there is economic value in the purchase of one Medigap policy, particularly from Blue Cross/Blue Shield or from a private health insurance company which, like Blue Cross, returns 90 to 95 percent of what they take in. The remainder is burned up in expenses, retained by the company as profit or divided up among its agents as commissions.

B. Value of Medigap policies

It is difficult for seniors to be prudent Medigap shoppers. There is little in the way of information to allow for comparison shopping. Measures of the actual worth of individual Medigap policies do sometimes exist, but are often not accessible to the average consumer. The following pages are devoted to these measures of policy worth and sugestions for consumers in choosing Medigap insurance.

One measure of an insurance policy's worth is called the loss ratio. Loss ratio is the proportion of gross premiums which, on the average, is returned to policy holders in the form of benefits. As such, its an indicator of economic value of policy form or forms offered for sale by an insurance company. Loss ratios are usually expressed in percentages. For example, if the loss ratio for a year (or other specific period) were 55 percent, this should mean that total benefits paid to policyholders—for illnesses starting during the period—would amount to 55 percent of the premiums which the had paid. Thus, from a consumer's point of view, the higher the loss ratio, the better the policy.

Although loss ratios can be used as measures of economic value, they do not reflect other factors which should be considered in determining economic value, such as:

What other insurance is available covering the same illness or other contingency;

The individual's financial situation; and

If the individual has other insurance covering the same contingency, will benefits payable on the new or existing policy be

released accordingly under provision for "coordination of benefits."?

Also, it is important to note that loss ratios are often presented as the average of all the insurance company's accident and health policies. This can afford some misleading information relative to individual Medigap policies. This presentation format may incorrectly lead one to believe that all of a company's health insurance policies, including Medigap, can be expected to return on average the same percentage of premiums taken in. Some examples taken from the 1985 Argus Guide and a 1975 report by the Wisconsin Department of Insurance serve to demonstrate this point well. While Mutual of Omaha Insurance Co. is listed a national loss ratio of 71 percent for all of its accident and health policies, its individual Medigap policies in force in Wisconsin have loss ratios from 37 percent to 57 percent with an average of 46 percent. Banker's Life and Casualty has an Argus listing of 73 percent loss ratio, yet its individual Medigap policies in Wisconsin have loss ratios ranging from 17 percent to 53 percent with an average of 42 percent. United American Insurance Co. has a listed loss ratio of 44 percent in the 1985 Argus Guide, yet its Medigap policies in the State of Wisconsin had loss ratios ranging from 11 percent to 68.1 percent with an average of 26 percent per policy in force.

Another important piece of information which should be considered when selecting an insurance policy is the relative financial position of the insurance company. Probably the most frequently used reference book in the insurance trade is Best's Insurance Report. Best's, available in some public libraries, gives an independent assessment of most insurance companies' financial strength, in the form of letter grades A+ to C. A high rating (toward A+) generally means that a company is financially sound. Many insurance companies and their agents use a high Best's rating as a major selling point for their policies.

In its June 1984 report on Medigap insurance, Consumer Reports offered the following suggestions for consumers using Best's:

> Unless you have independent knowledge of a company's financial condition, CU suggests buying health, life, or disability insurance only from a company rated A or higher. At best, the bankrupty of your health insurance carrier would subject you to a lot of redtape. At worst, it could leave you without coverage. . . . In our ratings, we regarded a Best's rating of A as normal. We gave extra credit to those companies that had an A+, and penalized those with grades below A. As nonprofit organizations, Blue Cross and Blue Shield plans are not rated by Best's.

It should be mentioned that while the relative financial strength of an insurer should be a part of any consumer evaluation of Medigap policy alternatives, it should not be used as the sole judge of a policy's worth. It is not impossible for a company to be strong financially because of its low benefit pay out rate.

Two other important elements of Medigap policies are the limitations they include related to preexisting and renewablity.

An important limitation of some policies is the presence of preexisting clauses. Some Medigap policies contain waiting periods and/or exlusions from coverage for conditions the policy holder has

when he or she bought the policy. A common waiting period is six months. For example, if a senior has a kidney ailment at the time he or she buys a Medigap policy with a standard 6 month preexisting condition waiting period. If the senior then as kidney failure two months later and then has very large medical bills not covered by Medicare, the Medigap policy will pay no benefits because the waiting period has not been met.

Another important consideration in evaluating Medigap policies is the renewability of policies. If a policy contains a clause which will allow the company to cancel the policy at any time, this means that the policy holder despite having paid premiums as requested, could be left with no protection. If, however, the policy states clearly that it is guaranteed renewable, the company cannot cancel the policy as long as the insured pays his or her premiums. This does not prohibit the company from raising premiums for the policy.

Consumers should also be on the look out for policies which are designated as "class cancellable" or "conditionally renewable." Under these types of policy provisions, the Medigap insurer cannot cancel just an individual policy, but it can cancel a senior citizen's policy if it cancels the entire group of policies of which the single policy is a part (all policies in one state, for example). There are also policies which state that they are renewable at the option of the company. Such Medigap policies can be cancelled on 30 days' notice, regardless of whether all the policies within its group are maintained.

While statistics on such group cancellations are not available, it is not uncommon for policies to be cancelled once the original pool of policy holders begin to put in more and more benefit claims against their policies. For example, in 1984 a Texas company that had been active in the Medigap field began cancelling the Medigap policies it had issued in the previous few years, apparently because it was losing money on them. It was reported that some 70,000 people were affected. The policies were not guaranteed renewable.

Experts also advise those senior citizens who can do so to buy group health insurance as opposed to individual policies. Most health insurance in America is sold on a group basis. Most typically employers provide coverage to their employees. Group plans afford many advantages. For one thing, they are less expensive since it costs less to insure a group of 100 individuals. Group policies are ususally more comprehensive as well. Group policy enrollees rarely have to take a physical exam to qualify for coverage and there are fewer exclusions from coverage and waiting periods prior to coverage are less common.

The problem with most group health plans has been that the group was generally made up of employees and when an individual retired, he or she left the group and hence lost coverage. However, in most cases senior citizens can convert their group coverage to an individual policy with the same company but the price of continuing the policy will generally be higher and the coverage may be more limited.

C. How Medigap is sold

As with many products and services, a key to a successful Medigap company is finding an effective way of marketing the product.

Medigap companies have historically been aggressive and innvovative in their marketing approaches. There are four general modes of selling Medigap insurance to the elderly:

(1) *Conversion.*—This selling mode, as described briefly above, involves the conversion of a health insurance policy held through one's job (usually as benefit) to a separate policy upon retirement. Typically, a retired person is forced to convert from his employer's group policy to an associated individual policy. The conversion from group to individual may require a prior medical exam, increased premiums and more limited coverage.

(2) *Mail order.*—A substantial number of Medicare supplement and indemnity plans are sold to the elderly by mail.

(3) *Salesmen.*—A good deal of Medigap insurance is sold by salesmen who visit seniors in their homes, in senior centers, hospitals and elsewhere. These salespeople are typically aggressive, fast talking, and pressuring. While there are some outstanding and very reputable Medigap sales agents, many are out to make the sale and will employ whatever tactics they feel will make the sale most probable. Medigap salespeople often have a very strong financial incentive to make sales. Most work on a commission basis, meaning that their income is a percentage of the total premiums taken in by the company from policies the agent has sold. This commission is often quite high. Data supplied to the subcommittee by the Wisconsin Department of Insurance indicates that agent commissions range from 0 percent to 70 percent of the total first year premium paid per policy sold.

In its landmark 1978 report "Abuses in the Sale of Health Insurance to the Elderly," the committee indentified widespeard abusive practices by Medigap salespeople. A litany of abuses were detailed ranging from overloading by selling elderly more insurance than they need, to make the check out to me schemes in which the agent would pressure the elderly consumer to sign a check over to the agent on the premise of purchasing a Medigap policy when in fact no coverage was being provided. The subcommittee, in an effort to determine if abuses persist, has conducted a follow up investigation in this area. The results of this investigation, detailed in section IV of this report, indicate that abuses in the sale of Medigap remain pervasive.

(4) *Television.*—The most prevalent and fastest growing type of Medigap marketing is through television advertising. Insurers offering mostly mail order Medigap coverage employ well known trusted television personalities to make emotional appealing endorsements of their products. The facts presented in these ads are often truthful. They are slick. Very rarely do the ads contain direct untruths, rather they provide incomplete and misleading information. Typically, these ads stress the potential financial catastrophe of a long drawn out hospital stay. They advise seniors that without additional protection, that they could find themselves with over $30,000 in hospital bills alone. What they don't mention is that only very few people will ever have a hospital stay of such lengths. Many of these TV ads imply that the policy being endorsed "pays everything

Medicare doesn't." What they fail to say is that this is only for Medicare-covered services and Medicare approved charges, leaving as much as half of health care costs uncovered. These advertisements play upon seniors' fear of rising health care costs and Medicare inadequacies, their great desire for health care security, as well as seniors' trust of and good feelings toward these television celebrities. These advertisements have been very successful, inducing thousands of seniors to buy the endorsed Medigap policy.

D. What seniors know about Medicare and Medigap

Considering the complexity of the subject, the lack of standardization, and the lack of useful consumer information, it is not surprising that senior citizens are often confused about Medigap. Many older Americans lack general knowledge about what Medicare and Medigap cover. A 1977 survey found, for example, that some 80 percent of seniors believed that Medicare would pay for nursing home care should they need it.

On May 23, 1986, the Subcommittee on Health and Long-Term Care sent out questionnaires to all 647 Area Agencies on Aging in the United States. The questionnaire was an attempt to update, on a national scale, the results of the identical questionnaire administered in 1977 to a sample of Florida residents by Zarrel V. Lambert, Liberty National Professor of Marketing in the School of Business at Auburn University mentioned previously. As the author himself stated in response to this findings of his exploratory study:

> "Many elderly consumers lack adequate knowledge about the financial risks associated with hospitalization, and the basic aspects of health insurance important in buying medigap policies."

His results, as well as those of the subcommittee, strongly demonstrate the lack of understanding most older people have regarding Medicare and policies which supplement its coverage.

According to Lambert, "The multitude of channels utilized in selling insurance create many opportunities for older consumers to make purchase decisions which waste, in one manner of another, substantial proportions of their limited funds or which leave them with protection expectations that will not be fulfilled should certain major illness occur." Lambert surmised that the presence of such large numbers of ill-prepared consumers adds fuel to questionable behavior and practices on the part of Medigap insurance sellers. The subcommittee's survey validated the Lambert 1977 survey.

Three weeks following the distribution of the survey, the subcommittee had reviewed responses from over 9,000 senior citizens. The analysis of their response follows.

THE 1986 QUESTIONNAIRE TO SENIOR CENTERS

The 1986 survey conducted by the Subcommittee on Health and Long-Term Care was begun on May 23, 1986. As was stated earlier, questionnaries were mailed to 647 Area Agencies on Aging, who in turn administered the survey to no fewer than 20 seniors at a senior center in their community. At the time this report went to press, about 9,000 senior citizens had responded to the survey.

The following charts, prepared in early 1986 by the Montgomery County (Maryland) Office of Consumer Affairs, provided a detailed analysis of the cost of typical Medicare supplemental health insurance policies.[3]

The subcommittee's survey elicited responses from seniors across the United States. Only four States, Montana, North Dakota, Wyoming, and Connecticut failed to respond. We found that the level of general understanding regarding Medicare coverage and its gaps was minimal. For example, only one-third of participating seniors realize that hospital insurance policies and coverage depends on the cause of illness. Three-quarters expect full coverage of hospital and medical expenses by their insurance company regardless of cost and only 8 percent of those participating understood the reasoning behind the loss ratio. The remainder of that 8 percent seemed to perceive a high loss ratio as a sign of rising premiums and unreliable coverage in the future.

The majority of seniors responding felt that Medicare would cover care in the home absent the need for skilled care, and that nursing home care would be covered. Both views are incorrect. Medicare will pay for home care if skilled care and other requirements are satisfied. Medicare seldom pays nursing home care, except if skilled care is required and even then a coinsurance requirement applies after the 20th day in such a facility.

The overall comparison between 1977 and 1986 is startling, in terms of consistency over time. In the last 8 years, seniors appear to possess less understanding of health insurance and its coverage. Attached are the responses to questions administered by AAA directors to senior citizens at senior citizen centers in 1986.

TABLE A

Question	Percentage answering correctly (age 65 and over)	
	1986	1980
(1) A policy that promises to pay a certain amount for each day a person is hospitalized usually provides benefits to a senior citizen that are quite different from the benefit provided by policies designed to pay hospital and doctor expenses that are not covered by Medicare. (True)	29	48
(2) An indemnity policy which promises to pay a certain amount for each day a person is hospitalized, say $40, typically will not pay more than this amount regardless of how much the hospital, doctor, and drug charges are each day. (True)	50	65
(3) A "preexisting conditions" clause in a hospital insurance policy means the company can refuse to pay claims due to current illness related to or developing from an illness or condition you had when you bought the policy. (True)	61	75
(4) Some health insurance policies—known as dread disease policies—will pay only if the policyholder gets a certain disease covered by the policy such as cancer. (True)	50	64
(5) Health insurance policies sometimes contain a clause that excludes payment for expenses resulting from certain kinds of illnesses or diseases to certain parts of the body. (True)	44	56
(6) Policies with a short time period during which claims can be denied due to preexisting conditions are usually the most advantageous for persons 65 and over. (True)	22	29
(7) If a company states that a hospital insurance policy is guaranteed renewable for life, this means the premiums can not be raised to exorbitant levels during the lifetime of the policyholder. (False)	43	42

[3] See pages 34 FF.

TABLE A—Continued

Question	Percentage answering correctly (age 65 and over)	
	1986	1980
(8) If a hospital insurance policy states it will pay certain hospital expenses, say so much a day for hospitalization, this means it will always pay for these expenses regardless of the cause of the illness that resulted in hospitalization. (False)	33	26
(9) If a policy states that certain hospital and medical expenses will be paid, the company must pay for these expenses regardless of how much they add up during a year or during the policyholder's lifetime. (False)	25	22
(10) Generally it is unwise for persons 65 and over to buy a hospital insurance policy on which the issuing company has a high loss ratio where a high percentage of the premiums collected are paid out in claim losses because the company in the future may raise premiums, cancel the policy, resist paying claims, or become financially unsound. (False)	8	3
(11) A person who cancels a hospital insurance policy and then immediately buys another policy will be without full coverage for a period of time because of "preexisting conditions" and/or "waiting period" clauses in the new policy. (True)	61	63
(12) In order to be covered by Medicare medical insurance (part B), most people 65 and over do not have to pay monthly premiums. (False)	59	75
(13) Medicare hospital insurance (part A) does not pay for the first $104 of hospital expense incurred by a person in each Medicare benefit period. (True)	60	71
(14) Beginning with the 31st day in a hospital, a person covered by Medicare hospital insurance (part A) must pay the first $26 per day of hospital expense. (False)	7	17
(15) A person covered by Medicare who is in the hospital longer than 90 days must pay the first $52 per day of hospital expenses beginning with the 91st day, and Medicare hosptial insurance (part A) pays the balance until a lifefime total of 60 reserve days of Medicare coverage is used. (True)	29	46
(16) If a person is admitted to a skilled nursing facility following at least a 3-day stay in the hosptial, Medicare hospital insurance (part A) will pay for all covered services for the first 20 days in the nursing facility if certain conditions are mre. (True)	31	55
(17) From the 21st through the 100th day in a skilled nursing facility, Medicare hospital insurance (Part A) helps pay covered services, but the person must pay the first $13 per day of expense for covered services. (True)	19	42
(18) Medicare medical insurance (part B) will pay only what is considered to be a "reasonable" charge or fee. If a doctor or hospital charges more that this amount, the person must pay the difference (True)	66	80
(19) Medicare medical insurance (part B) helps pay outpatient hosptial care, outpatient physical therapy and speech pathology services, and home health care which are not cevered by Medical hosptial insurance (part A). (True)	28	51
(20) Medicare medical insurance (part B) helps pay for doctor's services received in his office, in a hosptital, in a skilled nursing facility, and in a person's home. (True)	35	77
(21) If a person is an inpatient in a hospital, Medicare medical insurance (part B) pays 100 percent of the resonable charges by doctors for services in radiology and pathology. (True)	16	35
(22) Laboratory services and other diagnostic tests, except routing examinations, are covered by Medicare medical insurance (part B). (True)	24	63
(23) Medicare medical insurance (part B) does not pay for the first $75 of covered or Medicare approved medical expenses in each calender year. (True)	55	77
(24) Medicare medical insurance (part B) pays for no more than 80 percent of covered medical expenses, disregarding treatment for mental illness. (True)	50	75
(25) The home health care coverage under Medical hospital insurance (part A) and Medicare medical insurance (part B), may be combined under some circumstances to help pay for more than 100 days of home health care in a calendar year. (True)	13	34
(26) In order for home health to be covered by Medicare medical insurance (part B), the person must require part time skilled nursing care or therapy as determined by a doctor and the person must be convined to their home. (True)	36	51

The questionnaire obviously sparked much interest and curiosity at the senior centers about the senior's Medicare coverage and supplemental insurance. Numerous requests were made for a copy of the followup report on the survey and the answers to the questions. Many senior centers even brought in an expert in the field to

answer questions raised after the survey was completed. Directors are now attempting to develop educational programs for the seniors to enligthen them on Medicare and medigap. Excerpts expressing such concern follow:

> In implementing this survey, it became apparent to me that the AAA's need to provide additional training regarding Medicare and medigap insurance.
>
> Most of the seniors were even unclear as to the differences and costs of Medicare part A and Medicare part B.
>
> You may believe, however, that this is a topic near and dear to their hearts and the questionnaire precipitated quite a lively discussion and many questions.
>
> We have been educating Berkshire seniors, with speakers, articles in our senior newsletter, and informational material distributed to all; the medigap situation is often confusing, however, particularly when we are being barraged daily with mail offers of complete medigap coverage by private companies.
>
> It was an opportuntiy to do this survey. It told us where help is needed. The center director said that she has more questions on Medicare than on any other subject.
>
> Many people don't know what benefits they have, or what is covered under Medicare. They can't really buy a supplemental policy if they don't know what is already covered under Medicare.
>
> This certainly was a long and complicated questionnaire, but the 44 persons present in our dining room that took it stood by to provide feed back for your work. It's obvious that a large percentage are uniformed of the details of the coverage they carry. As one person expressed it, she hadn't had the need, therefore she didn't know the technicalities.
>
> The questions raised a great deal of interest among the senior citizens present. We would like to have an answer/explanation sheet for future discussion purposes.

Another finding of the subcommittee related to the general confusion seniors have regarding insurance due to its complexity. The following excerpts validate this observation:

> While we applaud your efforts to reopen the investigation of Medigap insurances, we feel the survey questions were too technical and complex to give you a fair reading of the knowledge of senior citizens about the basic attributes of health insurance. A representative of our area's Legal Aid office (who we consider to be an expert on Medicare and Medigap insurance) was present when we administered the survey and even he had difficulty answering the questions as stated.
>
> One woman told me that she was college educated and still found it difficult to answer questions. A retired nurse said it was difficult to answer the questionnaire. One conclusion we all agreed on was that Medicare is confusing. We applaud you for giving us the opportunity to give input

into the system and for checking with us to see where we are in understanding the Medicare program.

The questions were confusing and frustrating, and I realize that it is the extent of this confusion that this survey is partly intended to estimate.

Initially, we were uncertain whether the large number of "don't know" responses was because participants did not understand the rather complex questions or because they did not understand the issues involved. We realized, however, that the convoluted and complicated nature of the entire health insurance system negates the ability to ask simple questions, so the responses would be valid in either case.

It was very clear to me that these people, I work with need considerable educating in just what Medicare covers and does not cover. What a shame to have to depend on a system one cannot understand, let alone afford:

The majority of responses were accompanied by statements of support; expressions of agreement that Medicare is complex, inadequate and in need of reform:

Several elders at this meeting expressed concern about friends who have overlapping policies, some asked specific questions about their own policies, and others voiced their concern about the growing number of apparently sophisticated but confusing television advertisements for Medigap policies.

I applaud the work you are doing. If there is a way to communicate information or (God forbid) regulate the Medigap insurers to no longer allow them to make claims that are not true, you will have accomplished a miracle.

Clearly, the complexity and the confusion surrounding both Medicare and Medigap insurance leave the elderly as prime targets, that is, sitting ducks for slick, smooth talking, unethical salespersons who exploit the elderly's greatest fear—being left penniless and homeless due to long trem care bills.

Medigap insurance and changes in Medicare regulations and copayments are still very complex. Wouldn't it be simpler to have comprehensive national health insurance for all our citizens such as most other industrialized nations provide? Medicare is certainly becoming less and less comprehensive as the years go by. The real issue, it would seem to me, is an economic one: how can deductibles keep increasing at 15 to 20 percent per year when social security COLA's average is only 3 percent.

To help seniors evaluate Medigap policies available in their State, the Maryland Department of Aging analyzed those policies in detail and prepared the following brochure spelling out the differences on coverage.[4]

[4] Policies noted in these charts were selected from those in force in Maryland at the time. Differences in State regulation and corporate policy marketing may result in policy difference from State to State.

SERVICES	MEDICARE HOSPITAL INSURANCE PART A	AMERICAN INTEGRITY SENIOR SUPPLEMENT FORM SS-65-MD	AMERICAN INTEGRITY MASTER SUPPLEMENT FORM MMS-64-P-MD	AMERICAN NATIONAL LIFE FORM GMS-3-68	BANKERS LIFE & CASUALTY MEDICARE PLUS FORM BA-75A PLAN 2
PREMIUM OR SUBSCRIPTION CHARGES	NO CHARGE -- Credited for deductions under the Social Security Program	Age 65-72 - $581.05 per year 73-77 - 660.25 per year 78-82 - 710.10 per year 83 + - 756.15 per year	Age 65-69 - $768.20 per year 70-74 - 822.50 per year 75-79 - 865.50 per year 80-84 - 885.70 per year 85 + - 940.50 per year	AGE MALE FEMALE 65-69 $556 $498 per year 70-74 674 561 per year 75-79 800 654 per year 80-84 938 756 per year	Age 65-$480.25 71-$586.58 per year 66- 495.05 72- 617.78 per year 67- 504.65 73- 653.45 per year 68- 518.59 74- 693.70 per year 69- 538.61 75 +738.10 per year 76- 568.57
REGISTRATION FEE	NONE	$10 with application.	$10 with application.	NONE	NONE
PRE-EXISTING HEALTH CONDITIONS	NO RESTRICTIONS Covered from 1st day.	6 month waiting period for condition for which advice or treatment was received by physician within 6 months prior to Effective Date	90 day waiting period for any condition for which advice or treatment was received by physician within 6 months prior to Effective Date	6 month waiting period due to disease or physical condition requiring diagnosis or treatment within 6 months prior to the effective date of coverage.	90 day waiting period for medical condition that treatment or advice was recommended by doctor within 6 months before effective date.
DEDUCTIBLE ON ENTRY TO HOSPITAL	You must pay $492. Covers all of hospital costs for 60 days.	Pays the Medicare $492 deductible	Pays the Medicare $492 deductible	Pays the Medicare $492 deductible.	Pays the Medicare $492 deductible
COPAYMENT FOR THE NEXT 30 DAYS	You pay $123 per day. Medicare pays balance of hospital costs.	Pays the Medicare $123 copayment each day.	Pays the Medicare $123 copayment each day.	Pays the Medicare $123 copayment each day.	Pays the Medicare $123 copayment each day.
COPAYMENT FOR THE NEXT 60 DAYS "LIFETIME RESERVE"	You pay $246 per day. No portion of this period may be used again.	Pays the Medicare $246 copayment each day.	Pays the Medicare $246 copayment each day.	Pays the Medicare $246 copayment each day.	Pays the Medicare $746 copayment each day.
MAXIMUM PERIOD OF COVERAGE FOR ANY ONE BENEFIT	90 days plus any unused portion of "Lifetime Reserve."	Continues at 80% of charges for an additional 365 days in LIFETIME after Medicare benefits are exhausted.	Continues at 100% of reasonable charges incurred while confined.	Continues at 90% of Medicare Eligible hospital expenses not covered by Medicare for 365 more days in all benefit periods combined.	Continues at 100% of the Usual and Customary hospital care after the Medicare benefits are exhausted.
SKILLED NURSING FACILITY	Pays 100% for 1st 20 days with a copayment of $61.50 per day for the next 80 days. NO CUSTODIAL CARE!!	Pays the Medicare copayment of $61.50 per day from the 21st thru the 100th day.	Pays the Medicare copayment of $61.50 per day from the 21st thru the 100th day.	Pays the Medicare copayment of $61.50 per day from the 21st thru the 100th day.	*NOT COVERED
MEDICAL COVERAGE FOR PART B	PART B $75 deductible each year. Your cost is $15.50 per month	Pays the Medicare $75 deductible	Pays the Medicare $75 deductible	NOT COVERED. You pay the 1st $75.	NOT COVERED. You pay $75 deductible
OUTPATIENT CARE Physician Care for Hospital or Office Services, Surgery, Anesthesia, X-Ray, Laboratory, Injections, Splints, Casts, Dressings, Radiation Therapy, Physical Therapy, Ambulance, Prosthetics, etc.	Pays 80% of reasonable fees and charges.	Pays 20% of Medicare eligible expenses for a maximum of $5,000 in a calendar year.	Pays 20% of Medicare Approved Charges. -- IN ADDITION -- After you pay $200 in excess charges, company pays 80% of excess charges.	Pays 20% of Medicare allowable charges.	**Pays 20% of Medicare approved charges
OUTPATIENT PRESCRIPTION DRUGS	Pays 100% for IN-PATIENT ONLY.	NOT COVERED.	NOT COVERED.	NOT COVERED.	NOT COVERED.
RENEWABILITY OF CONTRACT	Cannot be cancelled.	Guaranteed renewable for life.	Guaranteed renewable for life.	Guaranteed renewable.	Guaranteed renewable for life.
TRAVEL RESTRICTIONS OUT OF AREA	Covered in U.S. or possessions. May use Canada or Mexico under certain conditions. See the Medicare Handbook.	Not covered outside of United States.	Not covered outside of United States.	Coverage is same as provided by Medicare	Covered to same extent as if received in the U.S.A.
Medicare & Insurance Supplement Comparison Guide for 1968 for the exclusive use by [illegible] Montgomery County, Maryland -- and prepared by [illegible] Division of Community	[illegible]	No health questions in application.	No health questions in application.		*Nursing Home Care and Part B deductible available at additional cost. **Higher Part B benefits also available.

SERVICES	MEDICARE HOSPITAL INSURANCE PART A	BENEFIT TRUST LIFE FORM MSP-102 MD	BLUE CROSS/BLUE SHIELD "65" LOW OPTION PLAN	BLUE CROSS/BLUE SHIELD "65" HIGH OPTION PLAN	COLUMBIA LIFE FORM MSP (10/0)
PREMIUM OR SUBSCRIPTION CHARGES	NO CHARGE -- Credited for deductions under the Social Security Program.	Age 65 - $ 794.81 per year 66-69 - 807.59 per year 70-74 - 1,026.74 per year 75-79 - 1,303.00 per year 80-84 - 1,416.39 per year 85 + - 1,657.58 per year	$311.28 per year. Covers under 65 on Medicare.	$1,125.72 per year. Covers under 65 on Medicare.	Age-65-69 - $578 per year 70-74 - 669 per year 75-79 - 749 per year 80-84 - 818 per year 85-89 - 886 per year
REGISTRATION FEE	NONE	NONE	NONE	NONE	NONE
PRE-EXISTING HEALTH CONDITIONS	NO RESTRICTIONS Covered from 1st day.	45 day waiting period for a condition for which medical advice or care was recommended during the 6 months before the Policy Date.	NO WAITING PERIOD. NO HEALTH QUESTIONS.	NO WAITING PERIOD. NO HEALTH QUESTIONS.	6 month waiting period for any condition for which medical advice or treatment was given within a six month period before Policy Date.
DEDUCTIBLE ON ENTRY TO HOSPITAL	You must pay $492. Covers all of hospital costs for 60 days.	Pays the Medicare $492 deductible.	Pays the Medicare $492 deductible.	Pays the Medicare $492 deductible.	Pays the Medicare $492 deductible.
COPAYMENT FOR THE NEXT 30 DAYS	You pay $123 per day. Medicare pays balance of hospital costs.	Pays the Medicare $123 copayment each day.	Pays the Medicare $123 copayment each day.	Pays the Medicare $123 copayment each day.	Pays the Medicare $123 copayment each day.
COPAYMENT FOR THE NEXT 60 DAYS "LIFETIME RESERVE"	You pay $246 per day. No portion of this period may be used again.	Pays the Medicare $246 copayment each day.	Pays the Medicare $246 copayment each day.	Pays the Medicare $246 copayment each day.	Pays the Medicare $246 copayment each day.
MAXIMUM PERIOD OF COVERAGE FOR ANY ONE BENEFIT	90 days plus any unused portion of "Lifetime Reserve."	Continues at 80% of Medicare eligible covered charges for hospital services for up to the 525th day.	Covers 90 days plus any unused portion of the "LIFETIME RESERVE."	Continues at 80% of Medicare Approved Expenses for an additional 365 days.	Continues at 80% of Medicare Eligible Expenses for an additional 365 days in your LIFETIME.
SKILLED NURSING FACILITY	Pays 100% for 1st 20 days with a copayment of $61.50 per day for the next 80 days. NO CUSTODIAL CARE!!	Pays the Medicare copayment of $61.50 per day from the 21st thru the 100th day, and then, 60% of daily room rate for an additional 80 days if needed.	Pays the Medicare copayment of $61.50 per day from the 21st thru the 100th day.	Pays the Medicare copayment of $61.50 per day from the 21st thru the 100th day.	Pays the Medicare copayment of $61.50 per day from the 21st thru the 100th day.
MEDICAL COVERAGE FOR PART B	PART B $75 deductible each year. Your cost is $15.50 per month.	*Pays the Medicare $75 deductible.	Pays the Medicare $75 deductible for emergency services in hospital or in physicians' offices.	Pays the Medicare $75 deductible.	*NOT COVERED
OUTPATIENT CARE Physician Care for Hospital or Office Services, Surgery, Anesthesia, X-Ray, Laboratory, Injections, Splints, Casts, Dressings, Radiation Therapy, Physical Therapy, Ambulance, Prosthetics, etc.	Pays 80% of reasonable fees and charges.	Pays 20% of Medicare covered charges.	NOT COVERED	Pays 20% of Medicare approved expenses.	**Pays 20% of Medicare Eligible Expenses OR the difference between Usual, Reasonable and Customary Charge and amount paid by Medicare, whichever is highest.
OUTPATIENT PRESCRIPTION DRUGS	Pays 100% as an IN-PATIENT ONLY.	Pays 80% after a Hospital stay and before Spell of Illness ends.	NOT COVERED.	Pays all costs at Participating Pharmacies except for a $5 deductible on each prescription.	NOT COVERED.
RENEWABILITY OF CONTRACT	Cannot be canceled.	Guaranteed renewable for life.	Reserves right to cancel.	Reserves right to cancel.	Guaranteed renewable for life.
TRAVEL RESTRICTIONS OUT OF AREA	Covered in U.S. or possessions. May use Canada or Mexico under certain conditions. See the Medicare Handbook.	Will cover Canada or Mexico out of United States but as provided by Medicare.	Foreign hospital coverage for maximum of $800.	Covers reasonable charges same as if you were home.	Covers same areas as provided by Medicare.
Medicare & Insurance Supplement Comparison Guide for 1990 for the exclusive use of Montgomery County, Maryland and prepared by John L. Elsesser of California.		*May eliminate deductible to lower premium.			*Optional rider available to cover the deductible. **Optional riders available to pay higher benefits.

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CONTINENTAL CASUALTY CNA XTRA CARE PLAN I FORM P1-67720-A10	CONTINENTAL CASUALTY CNA XTRA CARE PLAN II FORM P1-67720-A10	GOLDEN RULE MEDIGAP BASIC FORM GR-H-2.1b	GOLDEN RULE MEDIGAP PLUS FORM GR-H-2.1bP	LIFE & HEALTH OF AMERICA FORM LHA 500-A-MO	MUTUAL OF OMAHA MUTUAL CARE FORM MH — SERIES 12921
AGE MALE FEMALE 65-69 $376.56 $328.01 per year 70-74 453.83 380.73 per year 75-79 541.98 454.34 per year 80-84 622.24 526.32 per year 85 + 715.70 603.38 per year	AGE MALE FEMALE 65-69 $551.85 $496.73 per year 70-74 668.55 581.94 per year 75-79 802.24 702.73 per year 80-84 925.21 823.92 per year 85 + 1,062.85 954.15 per year	ALL AREAS $400.00 per year	Zip Code Areas 202, 209-212, 214-219 $631.94 per year. Zip Code Areas 200, 203, 207-208 $752.69 per year.	Age 70 & under - $701.50 per year 71-80 - 778.80 per year 81 + - 918.50 per year	Age 65-69 - $327.00 per year 70-74 - 400.68 per year 75-79 - 438.12 per year 80 + - 479.76 per year
NONE	NONE	NONE	NONE	$15 with application.	NONE
6 month waiting period for condition for which medical treatment or advice was rendered in the 1st 6 months before your effective date of policy. No health questions on application.	6 month waiting period for condition for which medical treatment or advice was rendered in the 1st 6 months before your effective date of policy. No health questions on application.	No waiting period for pre-existing health conditions if fully disclosed in application.	No waiting period for pre-existing health conditions if fully disclosed in application.	6 month waiting period for condition for which medical advice or treatment was received within 6 months before the policy Effective Date.	6 month waiting period for any condition for which medical advice or treatment was received within 6 months before the policy date.
Pays the Medicare $492 deductible.	Pays the Medicare $492 deductible.	Pays the Medicare $492 deductible.	Pays the Medicare $492 deductible.	*Pays the Medicare $492 deductible.	Pays the Medicare $492 deductible.
Pays the Medicare $123 copayment each day.	Pays the Medicare $123 copayment each day.	Pays the Medicare $123 copayment each day.	Pays the Medicare $123 copayment each day.	Pays the Medicare $123 copayment each day.	Pays the Medicare $123 copayment each day.
Pays the Medicare $246 copayment each day.	Pays the Medicare $246 copayment each day.	Pays the Medicare $246 copayment each day.	Pays the Medicare $246 copayment each day.	Pays the Medicare $246 copayment each day.	Pays the Medicare $246 copayment each day.
Continues at 90% of Eligible Expenses for an additional 365 days in your LIFETIME.	Continues at 90% of Eligible Expenses for an additional 365 days in your LIFETIME.	Continues at 90% of Medicare Eligible Charges for a LIFETIME maximum of 365 days.	Continues at 100% of Medicare Eligible Charges for LIFE if needed.	Continues at 100% of Eligible Expenses for up to an additional 365 days during your LIFETIME.	Continues at 90% of hospital charges for an additional 365 days as your LIFETIME benefits.
NOT COVERED.	Pays the Medicare copayment of $61.50 per day from the 21st thru the 100th day.	*Pays the Medicare copayment of $61.50 per day from the 21st thru the 365th day.	*Pays the Medicare copayment of $61.50 per day from 21st thru 100th day, and then, $123 per day thru the 365th day.	Pays the Medicare copayment of $61.50 from the 21st thru the 365th day.	*Pays the Medicare copayment of $61.50 per day from the 21st thru the 100th day, and then, $20 per day for an additional 100 days if needed.
NOT COVERED. You pay $75 deductible.	Pays the Medicare $75 deductible.	NOT COVERED. You pay $75 deductible.	Pays $15 of the Medicare deductible. You pay balance of $60.	*Pays the Medicare $75 deductible.	NOT COVERED. You pay the $75 deductible.
Pays 20% of eligible expenses AFTER YOU PAY $200 OF THE AMOUNT MEDICARE ALLOWS INCLUDING $75 DEDUCTIBLE.	*Pays 20% of Medicare allowable charges.	Pays 20% of Medicare Approved Charges up to a $5,000 maximum benefit per year.	**Pays 20% of Medicare Approved Charges and 80% of non-approved charges, after a $50 deductible.	Pays 20% of Medicare approved charges for a maximum of $5,000 per calendar year.	Pays 20% of Medicare Allowable Charges for a maximum of $5,000 in a calendar year.
NOT COVERED.	NOT COVERED.	NOT COVERED.	**Pays 80% of Reasonable and Customary Charges, after a $50 deductible.	NOT COVERED.	NOT COVERED.
May not renew your policy if it does not renew all such policies in your state.	May not renew but must receive prior approval of the Insurance Commissioner.	Guaranteed renewable for life if no misstatements in application.	Guaranteed renewable for life if no misstatements in application.	Guaranteed renewable.	Company reserves right to cancel.
In-hospital care covered by a daily indemnity of $123 per day for up to 30 days.	In-hospital care covered by a daily indemnity of $123 per day for up to 30 days.	Covered in U.S. only.	Covered in U.S. only.	Coverage same as provided by Medicare.	Optional Rider is available for coverage outside of U.S.
	*Optional rider available for 40% benefit.	*Also covers facilities not approved by Medicare.	*Also covers facilities not approved by Medicare. **One $50 deductible covers both benefits.	*Optional Riders available to reduce premiums if you pay the deductibles.	*Also provides coverage in facilities not approved by Medicare.

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SERVICES	MEDICARE HOSPITAL INSURANCE PART A	MUTUAL OF OMAHA MUTUAL CARE PLUS FORM M66 — SERIES 12823	NATIONAL CASUALTY FORM 8427 RUG	NATIONAL COUNCIL OF SENIOR CITIZENS — SENTRY INSURANCE EXPANDED PLAN	NEW YORK LIFE FORM 8146—1
PREMIUM OR SUBSCRIPTION CHARGES	NO CHARGE - Credited for deductions under the Social Security Program	65-69 $485.80 per year 70-74 573.12 per year 75-79 627.95 per year 80 + 688.60 per year	AGE MALE FEMALE 65-69 $738 $641 per year 70-74 [illegible]21 724 per year 75-79 871 814 per year 80 + 1,076 887 per year	$559.70 per year	AGE MALE FEMALE 65-69 $528.00 $488.40 per year 70-74 613.80 567.60 per year 75-79 686.40 627.00 per year 80-84 732.60 693.00 per year
REGISTRATION FEE	NONE	NONE	NONE	Group membership	NONE
PRE-EXISTING HEALTH CONDITIONS	NO RESTRICTIONS Covered from 1st day	6 month waiting period for any condition for which medical advice or treatment was received within 6 months before the policy date.	6 month waiting period for a condition for which you were given medical advice or treatment within 6 months prior to the policy Effective Date.	6 month waiting period for a condition you were given medical diagnosis or treatment within 6 months prior to the effective date. No health questions on application.	ACCEPTANCE IS GUARANTEED with 6 month waiting period due to advice or treatment received from physician within 6 months before the policy date.
DEDUCTIBLE ON ENTRY TO HOSPITAL	You must pay $492. Covers all of hospital costs for 60 days.	Pays the Medicare $492 deductible.	Pays the Medicare $492 deductible.	Pays the Medicare $492 deductible.	Pays the Medicare $492 deductible.
COPAYMENT FOR THE NEXT 30 DAYS	You pay $123 per day. Medicare pays balance of hospital costs.	Pays the Medicare $123 copayment each day.	Pays the Medicare $123 copayment each day.	Pays the Medicare $123 copayment each day.	Pays the Medicare $123 copayment each day.
COPAYMENT FOR THE NEXT 60 DAYS "LIFETIME RESERVE"	You pay $246 per day. No portion of this period may be used again.	Pays the Medicare $246 copayment each day.	Pays the Medicare $246 copayment each day.	Pays the Medicare $246 copayment each day.	Pays the Medicare $246 copayment each day.
MAXIMUM PERIOD OF COVERAGE FOR ANY ONE BENEFIT	90 days plus any unused portion of "Lifetime Reserve."	Continues at 100% of hospital charges for an additional 365 days as your LIFETIME benefits.	Continues at 80% of Medicare Eligible Expenses for an additional 365 days as a LIFETIME maximum.	Continues at 100% of all Medicare Eligible Expenses up to 365 days in your LIFETIME.	Continues at 100% of all covered charges within reason for up to an additional 365 days in your LIFETIME.
SKILLED NURSING FACILITY	Pays 100% for 1st 20 days with a copayment of $61.50 per day for the next 80 days. NO CUSTODIAL CARE!!	Pays 150% ($92.25) of the Medicare copayment each day from the 21st thru the 100th day.	Pays the Medicare copayment of $61.50 per day from the 21st thru the 100th day and $123 per day for an additional 365 days in your LIFETIME.	Pays the Medicare copayment of $61.50 per day from the 21st thru the 100th day, and then, $100 per day for an additional 265 days if needed.	Pays the Medicare copayment of $61.50 per day from the 21st day thru the 100th day.
MEDICAL COVERAGE FOR PART B	PART B $75 deductible each year. Your cost is $15.50 per month.	Pays any unpaid portion of $75 deductible if HOSPITAL CONFINED ONLY.	NOT COVERED — You pay the $75.	NOT COVERED. You pay the $75 deductible.	NOT COVERED — You pay $75 deductible.
OUTPATIENT CARE Physician Care for Hospital or Office Services, Surgery, Anesthesia, X-Ray, Laboratory, Injections, Splints, Casts, Dressings, Radiation Therapy, Physical Therapy, Ambulance, Prosthetics, etc.	Pays 80% of reasonable fees and charges.	Pays 30% of Medicare Allowable Charges.	* Pays 20% of Medicare Eligible Expenses.	*Pays 20% of Medicare Eligible Expenses.	Pays 20% of ALL CHARGES WITHIN REASON.
OUTPATIENT PRESCRIPTION DRUGS	Pays 100% as an IN-PATIENT ONLY.	NOT COVERED.	NOT COVERED.	NOT COVERED.	NOT COVERED.
RENEWABILITY OF CONTRACT	Cannot be cancelled.	Company reserves right to cancel.	Guaranteed renewable for life.	May terminate if you give up membership, default premium, give up Medicare, or Group Policy is terminated.	Guaranteed renewable.
TRAVEL RESTRICTIONS OUT OF AREA	Covered in U.S. or possessions. May use Canada or Mexico under certain conditions. See the Medicare Handbook.	Optional Rider is available for coverage outside of U.S.	Covers in U.S.A. only.	NOT COVERED outside of U.S.A.	Coverage is same as provided by Medicare.
Medicare & Insurance Supplement Comparison Guide for 1986 for the exclusive use by Montgomery County, Maryland and prepared by John L. Knowlen of California.		*Also provides coverage in facilities not approved by Medicare.	*Optional plans available to pay 30% or 40% for Part B benefits.	*Two optional plans available to provide lower benefits and premium charges.	

PRUDENTIAL/AARP SUPPLEMENT PLUS FORM 99-3*	PRUDENTIAL/AARP EXTENDED SUPPLEMENT FORM 95-3*	PRUDENTIAL/AARP COMPREHENSIVE SUPPLEMENT FORM 91-4*	RESERVE LIFE PLAN I FORM GL95RD4	RESERVE LIFE PLAN II FORM GL95RD4	STATE FARM MUTUAL FORM SV92R
$17.95 per month.	$30.25 per month.	$69.95 per month	Age 65-69/5.76 71-69/8.92 77-81/10.25 65- 720.31 72- 885.22 78- 1,092.75 67- 759.34 73- 921.55 69- 1,084.59 69- 783.65 74- 946.92 80- 1,125.54 69- 814.08 75- 971.75 84- 1,163.59 70- 842.49 76- 1,025.47 85- 1,182.35	Age 65-1,082.48 71-1,359.48 77-1,699.82 66-1,116.65 72-1,375.27 78-1,634.62 67-1,164.41 73-1,414.92 69-1,688.99 68-1,216.92 74-1,464.44 80-1,737.31 69-1,254.63 75-1,493.44 84-1,781.69 70-1,287.27 76-1,559.75 85-1,857.13	Age 65-69 - $365.50 per year 70-74 - 477.70 per year 75 + - 572.00 per year
Group Membership.	Group Membership.	Group membership.	$20 with application.	$30 with application.	$10 membership fee.
3 month waiting period for any condition for which medical advice or treatment was received within 6 months before policy date.	3 month waiting period for any condition resulting in your receiving medical advice or treatment within 6 months prior to the Effective Date of policy.	3 month waiting period for any condition for which medical advice or treatment was received within 6 months before policy date.	180 day waiting period for condition for which medical advice or treatment was recommended within 180 days prior to the effective date of the coverage.	180 day waiting period for condition for which medical advice or treatment was recommended within 180 days prior to the effective date of the coverage.	6 month waiting period for any condition for which medical advice or treatment was given within a 6 month period preceding the effective date of coverage.
Pays the Medicare $492 deductible.	Pays the Medicare $492 deductible.	Pays the Medicare $492 deductible.	Pays the Medicare $492 deductible.	Pays the Medicare $492 deductible.	Pays the Medicare $492 deductible.
Pays the Medicare $123 copayment each day.	Pays the Medicare $123 copayment each day.	Pays the Medicare $123 copayment each day.	Pays the Medicare $123 copayment each day.	Pays the Medicare $123 copayment each day.	Pays the Medicare $123 copayment each day.
Pays the Medicare $246 copayment each day.	Pays the Medicare $246 copayment each day.	Pays the Medicare $246 copayment each day.	Pays the Medicare $246 copayment each day.	Pays the Medicare $246 copayment each day.	Pays the Medicare $246 copayment each day.
Continues at 100% of Medicare Eligible Expenses up to 365 days in your LIFETIME.	Continues at 100% of Medicare Eligible Expenses up to 365 days in your LIFETIME.	Continues at 100% of Medicare Eligible Expenses up to 365 days in your LIFETIME.	Continues at 100% of Medicare Eligible Charges for a LIFETIME maximum of 400 days.	Continues at 100% of Medicare Eligible Charges for a LIFETIME maximum of 400 days.	Continues at 80% of Medicare Eligible Expenses for a LIFETIME benefit of 365 days.
Pays the Medicare copayment of $61.50 per day from the 21st thru the 100th day, and then, $123 per day thru the 365th day.	Pays the Medicare copayment of $61.50 per day from the 21st thru the 100th day, and then, $123 per day thru the 365th day.	Pays the Medicare copayment of $61.50 per day from the 21st thru the 100th day; then $123 per day thru the 365th day.	Pays the Medicare copayment of $61.50 per day from the 21st thru the 100th day.	Pays the Medicare copayment of $61.50 per day from 21st thru the 100th day, then 50% of daily CHARGE up to a maximum of $10,000 as a LIFETIME benefit.	Pays the Medicare copayment of $61.50 per day from the 21st thru the 100th day.
NOT COVERED — YOU PAY THE FIRST $200.	NOT COVERED. You pay the $75 deductible.	NOT COVERED — You pay $75 deductible.	Pays the Medicare $75 deductible.	Pays the Medicare $75 deductible.	Pays the Medicare $75 deductible.
Pays 20% of Medicare Eligible Expenses AFTER YOU PAY THE $200 DEDUCTIBLE.	Pays 20% of Medicare Eligible Expenses.	Pays 100% of the usual and prevailing expenses not paid by Medicare.	Pays 20% of Medicare Eligible Charges.	Pays 20% of Medicare Eligible Charges plus 50% of difference between Eligible Charge and Usual Charge up to $2,500 per calendar year.	Pays 20% of Medicare allowable charges
NOT COVERED.	Pays 50% of usual & [illegible] expenses after $50 calendar year deductible and for up to $5,0[illegible] each year.	Pays 50% of usual and prevailing expenses after $50 calendar year deductible and for up to $500 each year.	NOT COVERED.	NOT COVERED.	NOT COVERED.
Company reserves right to cancel.	Company reserves right to cancel.	Company reserves right to cancel.	Guaranteed renewable.	Guaranteed renewable.	Company reserves right to cancel.
Pays 80% of reasonable charges for covered expenses up to $25,000 when you pay $50 deductible.	Pays 80% of reasonable charges for covered expenses up to $25,000. You pay $50 deductible.	Pays 80% of reasonable charges for covered expenses up to $25,000. You pay $50 deductible.	Coverage is same as provided by Medicare.	Coverage is same as provided by Medicare.	Not covered outside of United States
*Other plans available with lower or higher benefits.	*Other plans available with lower or higher benefits.	*Other plans available with lower premiums and benefits.	* $9 annual policy fee, also	*$20 annual policy fee, also.	

SERVICES	MEDICARE HOSPITAL INSURANCE PART A	UNION BANKERS SENIOR HEALTHCARE FORM 7005—10	UNITED AMERICAN CONTINENTPART V-PLUS FORM MAXC + (10)	COLUMBIA MEDICAL PLAN HMO*	GROUP HEALTH ASSOCIATION HMO*
PREMIUM OR SUBSCRIPTION CHARGES	NO CHARGE - Credited for deductibles under the Social Security Program	Age 65-69 — $588.76 per year 70-74 — $25.81 per year 75-79 — $66.48 per year 80 + — $48.48 per year	$726 per year	$52 per month. Increase quarterly.	$48.55 per month.
REGISTRATION FEE	NONE	NONE	$10 with application	NONE	$25 with application.
PRE-EXISTING HEALTH CONDITIONS	NO RESTRICTIONS Covered from 1st day.	90 day waiting period for any medical conditions that began or were treated within 6 months before the effective date of coverage.	90 day waiting period for which medical treatment or advice was recommended by or received from a physician within 6 months prior to policy effective date.	NO WAITING PERIOD after application is approved.	NO WAITING PERIOD after application is approved. Acceptance based on applicants health and credit status.
DEDUCTIBLE ON ENTRY TO HOSPITAL	You must pay $492. Covers all of hospital costs for 60 days.	Pays the Medicare $432 deductible.	Pays the Medicare $492 deductible.	COVERED IN FULL.	COVERED IN FULL.
COPAYMENT FOR THE NEXT 30 DAYS	You pay $123 per day. Medicare pays balance of hospital costs.	Pays the Medicare $123 copayment each day.	Pays the Medicare $123 copayment each day.	COVERED IN FULL.	COVERED IN FULL.
COPAYMENT FOR THE NEXT 60 DAYS "LIFETIME RESERVE"	You pay $246 per day. No portion of this period may be used again.	Pays the Medicare $246 copayment each day.	Pays the Medicare $246 copayment each day.	COVERED IN FULL.	COVERED IN FULL.
MAXIMUM PERIOD OF COVERAGE FOR ANY ONE BENEFIT	90 days plus any unused portion of "Lifetime Reserve."	Continues at 100% of the Usual and Customary expense charges after Medicare benefit ends.	Continues at 100% after Medicare benefit ends and pays eligible hospital expenses for AS LONG AS CARE IS NEEDED.	COVERED IN FULL for as long as needed (except mental health).	COVERED IN FULL for as long as needed.
SKILLED NURSING FACILITY	Pays 100% for 1st 20 days with a copayment of $61.50 per day for the next 80 days. NO CUSTODIAL CARE!!	*NOT COVERED.	Pays the Medicare copayment of $61.50 per day from the 21st day thru the 365th day if needed.	COVERED IN FULL WITH NO LIMIT ON NUMBER OF DAYS.	COVERED IN FULL WITH NO LIMIT ON NUMBER OF DAYS.
MEDICAL COVERAGE FOR PART B	PART B $76 deductible each year. Your cost is $15.50 per month.	Pays the Medicare $75 deductible.	*SEE BELOW	COVERED IN FULL.	COVERED IN FULL.
OUTPATIENT CARE Physician Care for Hospital or Office Services, Surgery, Anesthesia, X-Ray, Laboratory, Injections, Splints, Casts, Dressings, Radiation Therapy, Physical Therapy, Ambulance, Prosthetics, etc.	Pays 80% of reasonable fees and charges.	*Pays 20% of Medicare allowable charges	*In each calendar year pays half of the 1st $400 of Covered Expenses not paid by Medicare, then pays all additional Covered Expenses incurred up to 140% of the amount approved by Medicare	COVERED IN FULL with co-payment of $4 per visit — $10 per home visit. Includes routine immunizations, eye and hearing exams and periodic health exams. Laboratory and radiology service covered in full.	Covered in full except NO SPEECH THERAPY (unless part of rehabilitation program), NO ORTHOPEDIC APPLIANCES, NO DURABLE MEDICAL EQUIPMENT, NO BLOOD, but does cover administering cost. Does cover routine immunizations.
OUTPATIENT PRESCRIPTION DRUGS	Pays 100% as an IN-PATIENT ONLY.	NOT COVERED.	NOT COVERED.	$4 copayment for prescriptions or refills but must be purchased from a Plan Pharmacy.	Covered in full after you pay the first $500 each year.
RENEWABILITY OF CONTRACT	Cannot be cancelled.	Reserves right not to renew.	Guaranteed renewable for life.	May be disenrolled if a satisfactory relationship cannot be established, failure to pay premiums or copays, or wrong use of ID card.	Renewability is automatic.
TRAVEL RESTRICTIONS OUT OF AREA	Covered in U.S. or possessions. May use Canada or Mexico under certain conditions. See the Medicare Handbook.	Coverage is same as if provided by Medicare.	Coverage is same as provided by Medicare.	World-wide coverage for emergencies only.	World-wide coverage for emergencies only.
* Medicare B Insurance - Supplement Completion Guide for 1988 for the exclusive use by Montgomery County, Maryland - and prepared by [illegible] Services of Colorado, [illegible]		*Optional Riders provide partial coverage for Skilled Nursing Facility and increases Part B benefits	*$200 is the most you pay in any calendar year for Part B	*Evaluating Risk Contract. Columbia HMO is a subsidiary of Blue Cross/Blue Shield. Covers Columbia, portions of MONTGOMERY and other Counties, and portions of Baltimore.	*Risk Contract under study. Covers MONTGOMERY, Prince Georges, Howard, and northern Charles Counties in MD, Washington, D.C., and several VA counties.

IV. ABUSES IN THE SALE OF MEDICARE SUPPLEMENTAL INSURANCE TO THE ELDERLY

It comes as no surprise that our Nation's older Americans are the most frequent targets of fraud and abuse in the health insurance marketplace. Their search for health security, as previous sections of this report document, is more intense than that of their younger counterparts. They live in daily fear that a long, drawnout catastrophic illness will strike, and that absent health insurance protection, they will be left bankrupt with little ability to recoup their losses in their retirement years. Their fears are well founded. When seniors do get sick, on the average they are hospitalized about three times as frequently and stay sick three times as long as their younger counterparts. It is this fear seniors have regarding their diminishing health status at a time when the costs associated with health care are increasing that makes them prime targets of health insurance abuses.

Abuses in the sale of health insurance to the elderly have been documented by the Congress, the States, local enforcement authorities and private consumer groups as early as 1965 when the State Special Committee on Aging conducted hearings into frauds against the elderly. In that same year, Medicare was enacted and the conventional wisdom at that time was that there would be no need for health insurance policies to supplement Medicare. As section II of this report suggests, that notion was ill founded. While Medicare was a godsend to senior citizens and literally no one would have it eliminated, seniors were still left paying over 50 percent of their health care bill and for many services like custodial nursing home care and in-home care, dental care and dentures, eye care and eyeglasses, hearing care and hearing aids, foot care, immunizations, routine doctor's visits, and out-of-hospital prescription drugs, and so forth. These gaps in Medicare coverage soon came to be filled by what is known today as Medigap insurance, or Medicare supplemental insurance. With the advent of Medigap insurance came the recognition of abuses in its sale.

The most common abuses noted by regulatory authorities and consumer advocates from 1965 to present include the following:

One: Agents misrepresenting coverage or using brochures which indicate benefits which are not provided by the policy.

Two: Agents recontacting long-time elderly insured and getting them to lapse policies to buy new ones.

Three: Passing the names of elderly, sometimes senile customers, from agent to agent and thus causing the multiple sale of insurance policies.

Four: Agents taking premiums for annual policies and having them issued on a quarterly basis to get large commission.

Five: Agents writing policies on sons, daughters, nephews, and nieces of elderly persons to avoid detection in their sale of duplicate policies.

Six: Agents tearing out riders from policies before delivery to the insured. The riders are generally preexisting condition clauses which exclude payment for various health conditions the insured may possess for a certain time up to 3 years.

Seven: Agents using high pressure sales tactics or scare tactics to sell the elderly more insurance than they need. Sometimes several agents may visit an old person at the same time to multiply the pressure on the aged to buy insurance.

Eight: Agents forging the signatures of the insured on policies or applications.

All of the above can be done with or without the knowledge and assent of the insurance company, as the 1978 investigation of the House Select Committee on Aging's report, "Abuses in the Sale of Medicare Supplemental Insurance to the Elderly," documented. The report noted, in part:

> The question of whether the insurance company is or should be liable for the abuses—misrepresentation or even fraud—by its agents is among the most troublesome in this field. Certainly one reason that many of the above abuses exist is the fact that many insurance companies pay little commission on renewals. Because of this, there is a great incentive for agents to write new policies which may average 70 percent of the first year's annual premium. Renewal commission may average as low as 5 percent in some companies. The problems are further facilitated by the fact that many insurance companies have chaotic recordkeeping systems and because they do not send out investigators to randomly review the sales their agents are making. It goes without saying that many companies are lax in their screening of agents in the first place.

What follows is a chronology of Federal, State, local, and private efforts relating to abuses in the sale of Medicare supplemental insurance to the elderly; an analysis of responses from State commissioners of insurance confirming abuses in the sale of Medicare supplemental insurance to the elderly (1978 to present); and, a summary of investigations of the House Select Committee on Aging and its Subcommittee on Health and Long-Term Care confirming abuses in the sale of Medicare supplemental insurance to the elderly (1978 to present).

A. CHRONOLOGY OF PUBLIC AND PRIVATE ACTIVITIES RELATING TO ABUSES IN THE SALE OF MEDICARE SUPPLEMENTAL INSURANCE TO THE ELDERLY

In 1965, the Medicare Program, our Nation's health insurance program for senior citizens, was enacted into law. As noted earlier, the new Medicare Program paid about one-half of the elderly's health care bill annually and seniors were left to insure themselves privately to fill those gaps not filled by the Medicare program.

The Senate Judiciary Committee's Subcommittee on Anti-Trust and Monopoly conducted a series of hearings in the summer of 1972 on the subject of "Commercial Health and Accident Insurance." This hearing record stands as the most detailed Federal evaluation of the health insurance industry following the enactment of the Medicare Program. The hearing focused on a series of questions posed by the chairman of the subcommittee, Senator Philip Hart, and responses from Edmund G. Pabst, executive vice

president of the Combined Insurance Company of America juxtaposed against those of former Pennsylvania Insurance Commissioner and consumer advocate, Herbert S. Denenberg. The questions, and excerpts of the responses, follow:

QUESTION 1. Are commercial accident and health insurance companies returning a sufficient amount of the (a) individual accident and health insurance; and (b) group accident and health insurance dollar in benefits to their customers?

Mr. PABST. We recognize that in the case of group insurance, the percentage of return can be higher than in the case of individual insurance. In the individual policy field the companies frequently do not have the economies of administration often present in group. Also since individual policies are sold on a person-to-person basis, the selling expense is ordinarily higher than for group.

Mr. DENENBERG. The cost-benefit ratio for many individual contracts is less than 50 percent. Some policies are returning as little as 5 to 10 percent of premiums in benefits to policyholders. Some types of policies, such as the cancer policy, typically return 30 to 40 percent of the premiums in benefits to policyholders.

Individual health insurance companies are burning up about a billion dollars a year in advertising and adminstrative expenses.

The public thinks it's buying medical care. In fact, it's pouring about half its spending on individual contracts into the excessive expenses of the commercial health insurers.

It gets too little protection for the billion that gets burned up in expenses of individual health insurance policies.

QUESTION 2. Should accident and health insurance policies be standardized by regulation?

Mr. PABST. Standardization of health insurance policy forms would not be in the best interest of the public, the providers of health care, or State regulation of the insurance business.

Standardization would stifle competition among insurers, discontinue the incentive for experimentation with new coverages, deter improvements in existing coverage, make it impossible to provide coverage based upon individual need, and would disregard the time tested use of provisions which are based upon the initiative of individual insurers.

Mr. DENENBERG. We would like to see about six standard policies and the disappearance of the gimmick, Mickey Mouse junk, and narrow coverage health policies which now pervade the health insurance market.

The process of standardization should be subject to administrative control and should not be locked into the rigid mold of a statutory prescription. Overly detailed and rigid benefit formula's can destroy the delivery system and make it unresponsive to new delivery methods and new health care technologies.

QUESTION 3. Should health insurance rates be regulated?

Mr. PABST. Accident and health insurance is subject to the jurisdiction of the insurance departments of the 50 States and the District of Columbia. Rates must be filed with most of the State insurance departments and in at least 20 States the departments may disapprove policy forms when benefits are found to be unreasonable in relation to the premium charged. States also review rates to maintain solvency of the insurers. There is a growing tendency on

the part of the insurance departments to review rates, particularly in the case of increases in premiums.

Mr. DENENBERG. One of our problems is we do not have adequate legislative authority, and it is very difficult to get good insurance legislation. There are a million things that I could talk about.

I spend 4 years revising the insurance laws. I have a stack of insurance laws, but I know what is realistic. I know if I would go to the Legislature and say I want authority to regulate health and life insurance rates, I would never get it.

We have asked for authority to set minimum standards for contracts, and we are having trouble getting it.

You have inadequate insurance laws and it is difficult to get the legislature to act. Unlike Congress, they are often unresponsive.

QUESTION 4. What, if any, overall structural and fiscal changes are necessary to effectuate a system of comprehensive health care and insurance including preventative health care services for all consumers regardless of their financial needs?

Mr. PABST. The industry was not satisfied with a mere statement of policy, even though it was endorsed by all the members of the association. Through its trade associations and through the work of individual companies the industry has done a number of things in recent years to help control its cost.

Mr. DENENBERG. Many of the policies promoted most vigorously include little or no outpatient coverage.

This emphasis on in-hospital coverage has an inflationary impact on the health delivery system. It makes it likely that the policyholder will pressure the doctor to admit for a condition that could be much more economically treated on an outpatient basis.

What is needed is commitment to change and reform by the public, by government, by the providers of health care, and by the insurers of health care. What we need is a partnership between the several States and Washington because all the trust we can bring to bear to solve our problems must be brought to bear—and soon.

QUESTION 5. What has the private health insurance industry done to reduce the ever escalating cost of health care?

Mr. PABST. The industry has also recognized the potential for reducing hospital utilization and the other potential advantages of prepaid group practice plans. The industry has participated in the development and marketing of such programs in Boston, MA; Columbia, MD; and elsewhere.

Mr. DENENBERG. The key to a good health delivery system is control over costs and quality. Without reasonable cost and quality controls money poured into health delivery is merely gobbled up by higher prices.

We have asked the commercial insurance companies to document their cost and quality control measures. On several occasions, we have asked them to testify at our hearings.

Most of the major commercial insurance companies have declined to testify, indicating that they would be represented by the Health Insurance Association of America—HIAA. And the representative of the HIAA has admitted that commercial insurance companies make little or no contribution to effective cost and quality control.

What this boils down to is that the HIAA has made legislative proposals. It has demonstrated little or no work at cost and quality control.

In 1974, Herbert S. Denenberg, Pennsylvania Insurance Commissioner, released polls showing 81 percent of the public had positive satisfaction with the insurance department and its service. He said that out of 21,000 complaints handled by the department each year, 47 percent related to auto insurance and 30 percent to the sale of health insurance policies.

Writing in "The Progressive," Denenberg described what he called "those health insurance booby traps. . . ." Everyone, of course, is terrified at the prospect of a major illness, but none more than the elderly. Denenberg wrote of "some of the devices that have been widely used by health insurers to mislead the public while making a handsome profit for themselves," including the following which were detailed in the 1978 committee report:

1.—They Offer Narrow Coverage but Make It Sound Liberal

A common figure offered as coverage is $50,000. It sounds substantial enough to cover any hospital bill, which is, of course, exactly the impression they want to give. In fact, if premiums are cheap it sounds like a bonanza. Union Fidelity Life Insurance Co. has mastered the bonanza technique.

Headlines scream that the company offers $50,000 in benefits, but what it really offers is about $20 a day if, and only if, you are in a hospital. Stay sick long enough—and in the hospital, not at home and not in a nursing home—and you will undoubtedly collect $50,000. But long enough in this case is about 5 years of continuous hospitalization, a virtual impossibility. So, the company offers the public some breathtaking amount—being sure to give the aggregate figure and not the daily figure.

The insurance company doesn't worry much about the claimant who does require a long hospital stay. Only 2 percent of all hospitalized people stay longer than 30 days, according to the extensive experience of one Blue Cross plan. Union Fidelity's spokesman at our public hearings said the average claim paid by his firm is $174. The largest payout was $10,000.

Another way these companies cut back on seemingly broad coverage is to build in a variety of limitations and restrictions. Denenberg refers to the exclusion for preexisting conditions. And then to cover themselves even more fully, some insurers use another restriction: They do not pay for the following diseases during the first 6 months of coverage: tuberculosis, gall bladder disorders, diabetes, cancer, heart or circulatory disease or disturbance, hernia, sickness resulting from surgery, or disease of the generative organs. (What's left?)

The really clever operator not only can make your coverage sound liberal, but also encourages consumers to

think they can make a fast buck by being hospitalized. Physician's Mutual Insurance Co. proclaims in bold red headline: "New extra cash plan so practical you may leave the hospital money ahead. Extra cash for sickness! Extra cash for accidents! Extra cash on top of other hospital benefits, even Medicare!"

2.—The Companies Make Sure Premiums Are Eaten Up in Expenses and Especially Profits

If the insured gets back more than 50 percent of his premium dollar, the insurance company is, by its standard, being generous relatively speaking. Denenberg reports that the National Liberty Corp. returned after tax profits three times that of blue chips such as American Telephone & Telegraph and the Chase Manhattan Bank. The company returned only 27 cents on each premium dollar and reached profits of up to 46.5 percent on one series of policies.

Mail order policies are intended to supplement regular health insurance, although the fact isn't always made clear in the advertising. Unhappily, a large portion of these policies are held by individuals with no other hospital insurance. Even for people who have basic insurance, extra coverage may be needed, but it should typically be a good major medical policy rather than one of the junk, gimmick policies featured by many mail order insurance companies.

A clever insurance company can establish the ultimate in low return—a dread disease policy that returns only 7 cents on the premium dollar. It would seem that the public would be too smart to fall for such a fraud, but millions of policyholders are paying premiums each year for such policies.

3.—The Companies Scare People, Especially the Elderly

The mail order operators prey on the fear of the old people. They suggest to them in the biggest headlines, that they must have health insurance or they will die in the paupers' ward. Or the company reminds them that they certainly don't want to be a burden to their relatives and children. They make them think that their policy can give them enough protection to solve the budget-crunching problems created by illness among retired persons. It doesn't matter to the exploiters that these people will invest a portion of their tiny income in these nearly useless policies. The more important thing to the exploiters is the money; if the policyholders don't understand the fine print, that's tough.

Another effective scare tactic is to push the idea that present coverage is not enough, whatever it is. Hospital costs are skyrocketing, therefore your coverage must be insufficient. The insurance promoters emphasize that they

provide $50,000 worth of coverage, which should be enough to cover your hospital expenses even in extreme cases. This is an effective technique in promoting policies to supplement Medicare. What promoters don't emphasize is that they pay only a small amount on a daily basis, and then only after the insured pays some of the cost as a deductible and only after they have been in the hospital 6 days under Medicare * * *.

All the mail order companies imply in their advertisements that coverage may not be available tomorrow, so you had better buy today. The tactic works well with health insurance. The fact that they will be offering coverage anew every few weeks is immaterial.

4.—The Companies Have Well Known, Trusted Personalities Endorse Their Policies

Among those listed by Denenberg were Art Linkletter for National Liberty Corp., Jack Benny for American Republic Insurance Co. of Des Moines, Paul Harvey for Bankers Life and Casualty, George Fenneman for Continental Casualty Co. Mail order hospital insurance companies are not the only ones which utilized the big name endorsement. Mutual of Omaha, for example, had been using Lawrence Welk to sell coverage. He had been telling his faithful, generally elderly viewers of his national television show the senior security policy of Mutual of Omaha is protection everyone over 64 should have. In Welk's endorsement, two basic principles were combined—the use of the big name personality giving his personal endorsement and the scare tactic. Mutual has now dropped the Welk ad at the request of the Pennsylvania Insurance Department.

5.—Mail Order Companies Use Phony Recommendations

Denenberg reports that Union Fidelity and National Liberty have claimed that their company is recommended by Best's Insurance reports. Best's does rate insurance companies for financial stability but says nothing about individual insurance policies. The most advanced form of a phony recommendation was developed by Union Fidelity. It assembled a consumer group whose sole reason for existence was to serve as its front for marketing the company's policies. As a result, Union Fidelity's right to do business was revoked by the District of Columbia in June 6, 1972.

6.—Insurance Exploiters Need Political Influence

Denenberg notes that more and more State insurance commissioners have begun to perceive their roles as protecting the consumer, not the insurance industry. The insurance industry, he says, will react by putting pressure on the Governor, in most States the only official who can hold down a conscientious commissioner. He notes that in a few States the insurance commissioner is elected and

subjected to political pressure, too. Political influence can be generated by loading the insurance company board of directors with as many former Governors and Senators as can be controlled. State legislators are also a good resource for these boards.

Denenberg ended by saying "the whole health insurance business needs a reexamination. The mail order health insurance investigation is only the first skirmish in a major battle against a health insurance system that does not serve the public well." He adds that the insurance industry has a big advantage. There are so many companies each with a myriad of insurance plans. "The biggest asset in the battle is the spotlight of public attention." He says regulation will help and that the goal is to provide the public with an honest representation of the varieties of insurance among which it may choose.

In May 1973, Consumer Reports (CR) published the results of their look into mail order health insurance. CR identified 170 companies which specialized in the sale of mail order health insurance. CR commented that while these companies presently account for only 2 percent of the total health insurance dollars, they are growing at an alarming rate, far greater than other conventional insurance companies.

In summary, whatever promise the concept of mail order health insurance might hold, only a few companies appear to be passing along any mass marketing savings to consumers in the form of a greater return on the premium dollar. Policies are now tied to hospitalization, negating most of the useful purpose they might serve as a form of major medical protection. And the strident advertising claims of large sums of tax free cash clearly attempt to exploit a human desire for big gains on small investments—gains that rarely materialize

Consumer Reports included a separate section on Medicare and mail order insurance:

> Odd as it may seem, the segment of the Americans society with probably the best overall insurance protection for hospitalization is the one most susceptible to the blandishments of the mail order merchants. That, of course, is the Medicare population. Five out of nine of such persons now hold some health insurance protection in addition to Medicare. The elderly are understandably concerned about their health and concerned about the blow a serious illness might be to their limited financial reserves.

The report notes:

> Mail order merchants sell supplementary health policies which are purportedly aimed at the Medicare gaps. One is the standard indemnity coverage—paying a fixed amount based on the number of days a policyholder spends in the hospital. The second is also indemnity but coverage begins only after the 60th hospital day. Neither type directly concerns Medicare's part A, part B or 20 percent copayment provisions. It is also important to note that the indemnity

> policies often pay reduced benefits to persons over age 65 for a number of hospital days, a point not made clear in many ads. National Liberty, for example, pays 70 percent of the advertised indemnity for the first 3 months in the hospital, then 100 percent.

Says Consumer Reports:

> Either type of mail order policy is inadequate to meet the real insurance needs of the Medicare group. The standard indemnity policy may indeed generate "extra cash," as the ads say, for the Medicare recipient who is hospitalized. But it doesn't relate to actual out-of-pocket expenses. Needless to say, with only 0.3 percent of the Medicare population, having a hospital stay exceeding 60 days in 1970, the 60-day deductible supplemental policy is a guaranteed moneymaker for the companies.

In December of 1974, the Senate Special Committee on Aging released an issue paper prepared by Gladys Ellenbogen entitled "Private Health Insurance Supplementary to Medicare." The report is based on interviews with State insurance commissioners in five States: California, Florida, Pennsylvania, Nevada, and Arizona. The introduction to the report says the five States represent 16 percent of the population over age 65 and include the top three States in terms of rate of growth of the aged population. "it is not a nationwide survey of State departments of insurance. On the other hand, it is hoped that its usefulness transcends the number of States chosen."

This report stood for years as the most detailed look at health insurance policies that supplement Medicare. The report concluded:

> Our consultations with departments of insurance in some States indicate there exists a common set of problems concerning private health insurance for the aged.
>
> Insurance departments consider the following to be among the major problems encountered by the elderly in their purchase of private health insurance: duplication of coverage, policies specifying flat dollar amount of payments without regard to rising health care costs, long waiting periods before the effective date on which the policy's protection begins, long preexisting condition periods and misleading advertising in the offering of policies.

The Senate report also mentions the selling tactics of some unscrupulous insurance agents:

> On this subject two particularly unfortunate practices are overinsurance and unwise cancellation of a policy with the simultaneous purchase of a new policy from the same agent.

On September 25, 1974, William J. Sheppard, then Pennsylvania Insurance Commissioner, announced an intense crackdown on insurance companies and their agents who have engaged in the disgraceful exploitation of the senior citizens of Pennsylvania through the sale of health insurance. He said that agents were revisiting

old customers and replacing existing policies, that they were passing around names of victims and thus causing multiple sales, that they were writing policies under a variety of names, that is Mary Smith, Mary A. Smith, M. Ann Smith to avoid detection of the multiple sales. He said they were writing policies on sons, daughters, nephews and nieces of the elderly and sometimes forging the signatures of applicants.

Commissioner Sheppard reported that 27 percent of the people reporting common health insurance abuses were senior citizens. He said that a severe problem existed in the Greater Pittsburgh area and announced the opening of several complaint centers to make sure that senior citizens are not taken advantage of by unscrupulous business tactics or agents.

The commissioner announced the results of his investigation in an October 31, 1974, speech before a group of senior citizens in Pittsburgh. He said the most shocking case involved an 80-year-old woman from Meadville, PA, who had spent $50,574 on 31 policies over a 3-year period, all of which had lapsed. Sheppard said the women's savings were wiped out and she even took out a $3,000 loan from her bank to make further payments. Sheppard contacted the presidents of the nine insurance companies involved and was able to get six companies to refund a total of $30,000 to the woman.

Many insurance agents are contacting elderly citizens and selling unnecessary policies, said the commissioner. Other folks are being encouraged to cancel their health insurance to buy new policies and thereby lose coverage for sicknesses they are fighting. Still other agents represent themselves as being from the Social Security Administration and then sell unnecessary commercial policies.

A special problem in the Greater Pittsburgh area is that disreputable agents had been inducing elderly citizens to believe purchases of life insurance policies with annuity riders are investments similar to mutual funds. Elderly consumers are encouraged to draw their life savings from the bank to make these purchases. They are erroneously led to believe that all their money may be refunded at any time the request is made.

Finally, some insurance companies deliberately stall payment of claims presented by senior citizens. We saw an elderly Indiana woman forced to go on welfare because an insurance company refused to pay her disability claim. Only after our intervention did the insurance company begin to pay what this 67-year-old woman was owed.

Commissioner Sheppard stated that there are several causes of the problem. First, the companies involved have been very lax in screening the type of agent they hire. We find many of these problem agents go from one such company to another, lapsing and rewriting their client's health insurance as they go. These companies only seem to care about placing new business on their books. Second, life-health insurance companies pay very little commission on renewals. Thus, there is an incentive for the unscrupulous agent to rewrite policies. Additionally, some of these companies pay a higher commission for shorter term policy.

The results of the investigations in Pennsylvania were far-reaching. The Department had investigated 24 companies it suspected of

violating law and regulations. At least 6 of the 24 companies were found to have posed serious problems for the elderly. Ten agents were indicted for criminal conduct such as fraud or forgery. Many more lost their licenses or their jobs. Hundreds of thousands of dollars were returned to the senior citizens who have been victimized. Moreover, some changes were implemented in the Pennsylvania regulations. However, for all the progress, Commissioner Sheppard reported on August 27, 1975, that health insurance complaints, although reduced in number, still ranked second in that State only to automobile insurance. He said the department handled about 20,000 complaints in the previous year relating to all kinds of insurance. Upon investigation, 46.9 percent of the claims were found to be valid.

In 1976, Consumer Reports (CR) published a report on "Health Insurance for Older People: Filing the Gaps in Medicare." The report included a useful line-by-line comparison of several Medicare supplemental insurance policies.

Consumer Reports also highlighted the techniques used by agents to victimize older insurance buyers and points out that the problem may not always be the unscrupulous agent but the careless insurance company. An example was provided of an insurance company whose certificates for coverage on two policies called for less extensive hospital coverage than was promised in the company's brochures.

While ranking 16 typical Medicare supplemental policies with CR felt were fairly typical, CR cautions, "None of the 16 covers all the medical expenses an older person might expect to occur. Nor will a combination of policies do the job. Yet older people often buy several policies, hoping to fill as many of Medicare's gaps as possible. This is understandable but expensive."

By way of recommendations, Consumer Reports suggested enrolling in a pre-paid health insurance plan otherwise known as a Health Maintenance Organization (HMO), adding that few HMO's are available and fewer still accept new patients over 65.

In early 1976, Oregon Gray Panthers working with the Legal Services Developer for the Elderly for the State of Oregon, Ron Wyden (now Congressman Ron Wyden, D-Oregon) began to agitate for regulations that would require each agent to advise the elderly (by giving them a chart) specifically what is and what is not covered by Medicare and to describe by this same method what gaps would be filled by the proposed policy to be purchased.

Their request was initially rebuffed by the State insurance commissioner, who said he had no authority to require companies to use such charts. However, hearings were called for September 1, 1976, and were attended by over 400 senior citizens.

According to Ron Wyden, 30 seniors testified at the all-day hearing on behalf of adopting the rules. Most persuasive testimony came from several retired insurance salesman and 86-year-old Grace Lapray of Salem, who was asked why she purchased four different policies with identical coverage from the same agent. He said, "Trust me," she explained.

In December of 1976, the Commissioner filed new regulations which required insurance agents to use a chart specifically showing Medicare's gaps and how they would be affected by any policy.

Comments Wyden, "Oregon's senior activists had won a major reform. No other State has yet provided the elderly with such a valuable reference tool to help with the purchase of supplementary medical insurance."

In Ohio, on November 1, 1977, Cilla Bosnak, a writer with the Dayton Journal Herald wrote about abuses in the sale of Medicare supplementary policies as discovered by Ohio Better Business Bureau director, Hazel Nolan:

> Illness and insurance agents both prey upon the elderly—sometimes at the same time * * * Older people are highly vulnerable both to illnesses and to misleading sales pitches. And they are easy targets for crafty agents or companies using "scare tactics" or misleading figures to sell insurance to clients already frightened by high hospital bills.

Bosnak reports that a questionable solicitation surfaced when someone complained to the Better Business Bureau about an apparent insurance solicitation through the mail.

You couldn't be sure it was insurance, however, because neither the company nor its address was included on the booklets—"A Pocket Guide to Medicare." And some of the literature bore a remarkable resemblance to a government Medicare publication.

Better Business Bureau Director Hazel Nolan said, "There is nothing to indicate this is an insurance agency. Nowhere does it talk about insurance. All it talks about is Medicare."

She said the insurance pitch used Medicare data and underscores the shortcomings of Medicare. "They scare the elderly to death," said Nolan. "This is one of the more horrible examples."

After a 2½-year investigation, marked by frustration trying to cope with abuses in the sale of Medigap policies, former Wisconsin Insurance Commissioner Harold Wilde gave a scathing speech calling for Government action to end what he called the "Medi-scare insurance racket, a multimillion dollar ripoff of our senior citizens." His speech is a landmark in this area and deserves to be quoted at length. In his preface, he hastened to point out that he was not criticizing all insurance companies or condemning all sales of supplemental policies to the aged. Excerpts follow:

> If I were to talk to you today about a multimillion dollar racket, that has swindled tens of thousands of Wisconsinites over the past few years—many of them poor or on fixed incomes—and were to add that, to my knowledge, none of the ringleaders in this racket has yet gone to jail, and some are still making hundreds of thousands of dollars a year at it—what would be your reaction? Anger? Outrage? Disbelief?
>
> Well that is precisely what I am going to do.
>
> The racket is the sale of ripoff insurance to people over age 65—the sale of what I call Medi-scare insurance.

The Commissioner added:

> We have greatly strengthened our enforcement efforts. We have increased the number of agent license revocations and suspensions from a handful in 1974 to 70 thus

far in 1977 alone. We have fined one company $25,000 and suspended it from the market for over a year. We have distributed over 15,000 of our booklets to senior citizens outlining their health insurance needs and rights. But the problem does not go away.

As a State insurance commissioner, I am wary of Federal insurance regulation. But this is a nationwide problem, created in part by a Federal program. I believe that—in the absence of a concerted national effort by the insurance industry—Federal action will be required to clean it up.

In Wisconsin, we are attempting to do all that we can do at the State level.

As part of their continuing surveillance of Medicare supplemental policies, the State of California brought legal action to revoke the licenses of two insurance salesmen, Donald B. Lee and Frances Dougherty in January of 1978.

The action against Lee contains numerous charges including the following as quoted from the legal documents filed in the case by then State Insurance Commissioner Wesley J. Kinder:

1. That Lee took an application from Gertrude Barsi and received a check from her in the amount of $133.64 which represented the premium on a nursing home policy to be issued on Mrs. Barsi's husband by Constitution Life Insurance Co. However, Lee failed to forward such application and the premium to Constitution, thereby exposing Barsi to the risk of loss and further failed to refund the premium until several months later when contacted by the State Commissioner of Insurance.

2. That Michael Kesslar, one of Lee's employees, took an application and received a check drawn by Ina Bellinger in the amount of $173.45 for a health policy. The check was deposited in Lee's trustee bank account. Lee did not send the premium and the policy to the insurer and thereby exposed Bellinger to the risk of loss. He failed to refund the premium until 6 months later when contacted by the State Insurance Commissioner.

3. That Lee induced William French to purchase two policies from Constitution Life Insurance Co., by falsely representing that thousands of policies of Blue Cross, their present employer, were either arbitrarily cancelled or having restriction added. Relying on these representations, French gave a check of $193.58 to Lee. Lee knew or should have known that the representations were false in that Blue Cross of Northern California was not arbitrarily cancelling or restricting health insurance policies. Lee's employee, Douglas Patricks, delivered the two policies to French and collected $71.51 from him as premium balance due and advised French to discontinue his existing Blue Cross insurance, which provided medical, surgical, and hospital benefits, because the Constitution Life policy also covered these expenses. Patricks, however, misrepresented the facts because the Constitution Life policy specifically excluded benefits for medical and surgical services rendered by a physician or surgeon. Moreover, Lee aided and abetted his employees Douglas Patricks and Michael Kesslar * * * to solicit in-

surance when he knew that they were unlicensed in the State of California. Lee signed the receipts and applications made by Patricks and Kesslar and appeared as the agent of record knowing that signing for sales made by others who are unlicensed is a violation of California law.

Unfortunately, Lee *et al.*, failed to obtain health insurance promised for many of the 39 individuals, thereby exposing them to risk of loss. They also failed to refund the money they collected.

With respect to Frances Dougherty, the commissioner found the following:

1. That she had received a $265.35 check from Fae Baldwin representing the premium on a health insurance policy from Globe Life. Instead of purchasing a policy or returning the money, she diverted and appropriated said funds to her personal use in violation of the California Insurance Code.

2. That she had received a check in the amount of $291.50 from G.B. Hylton representing the premium on a health insurance policy from United Insurance Co. obtained from Hylton's wife. The name of the payee was left blank on the check with the understanding that Dougherty would stamp in the name of the company. Dougherty made the check payable to herself, endorsed and cashed the check. She neither returned the money to Hylton nor obtained the requested policy for him.

3. That she induced Vera Gearing to purchase a hospital indemnity policy and a medical and surgical policy by falsely representing that both policies would cover the preexisting condition of her leg if Gearing paid an extra month's premium in advance on each policy. Relying on the representation that her leg condition would be covered, Gearing entered the hospital for treatment of the preexisting condition in her leg. The insurance company refused to pay and Gearing subsequently cancelled the policies. Dougherty either knew or should have known that preexisting conditions would not be covered. Obviously, this misrepresentation resulted in Gearing's not having any insurance coverage.

In summary, the commissioner concluded that Dougherty had "knowingly misrepresented the terms or effect of insurance policies for the purpose of inducing * * * the purchase of a policy of insurance * * * engaged in fraudulent practice and conducting her business in a dishonest manner; failed to perform duties required by the insurance laws of the State; offered to pay or paid unlawful rebates." Accordingly, the commissioner declared that it would be against the public interest to permit Dougherty to continue transacting insurance in the State of California.

These are but two of the case histories handled by the California Department of Insurance which has one of the most aggressive enforcement records in the Nation with respect to protecting senior citizens from insurance ripoffs.

In March 1978, a lawsuit was brought by several members of the American Association of Retired Persons (AARP) on behalf of all such members in the State of New York. The suit alleged that AARP is under the domination and control of the Colonial Penn Insurance Co., and that in essence AARP and its sister the Nation-

al Retired Teachers Association (NRTA) which together boast 11 million senior citizens as members, are fronts which the insurance company uses to increase its profits.

Instead of paying salesmen commissions, the suit alleged, Colonial Penn yearly made a several million dollar contribution to AARP/NRTA in the form of administrative expenses. The infusion of millions of dollars enables the association to keep its membership fees low—currently $3 a year for a person or a couple.

The lawsuit alleged that Colonial Penn has custody of the AARP/NRTA mailing lists—that no other insurance company was given either access to these lists or was permitted to advertise in NRTA/AARP publications, such as the magazine, Modern Maturity.

The suit charged that AARP policies were a bad buy because they paid indemnity benefits and returned only 62 percent of the premium dollar in claims as compared with 91 percent in the case of commercial insurers selling group policies.

The U.S. Postal Service has closed its investigation, having failed to find any evidence of inpropriety. In addition, AARP also points to a recent IRS ruling upholding our nonprofit tax exempt status as affirming the propriety of the relationship with Colonial Penn. The suits brought by New York AARP members and by Harriet Miller are pending.

During the last week of February 1978, the Newark Star Ledger ran an important special report which exposed abuses in the sale and regulation of Medicare supplemental insurance policies in the State of New Jersey. The articles by reporter Herb Jaffee began:

> More than half a billion dollars a year are paid by Jerseyans for health insurance policies that are neither regulated, carefully scrutinized by the State nor formally approved by the insurance commissioner.
>
> In some cases, these policies and their fine print and vague disclosures of benefits sold by agents of commercial insurance companies are designed to deceive and exploit unwary policyholders.
>
> Instances of relatively useless health insurance policies for which consumers have paid annual premiums ranging into several hundreds of dollars have been discovered by the Star-Ledger.

Jaffee charged that many policies sold to senior citizens had little economic value in reality. He reported that some companies encouraged unethical practices on the part of their agents. He quoted New Jersey officials as saying they couldn't remember the last time an insurance agent's license was revoked in connection with the sale of health insurance.

The recent interest in Medicare supplemental insurance policies was greatly fueled earlier this year by 2 days of hearings conducted by the Senate Special Committee on Aging. Senator Lawton Chiles chaired the Senate hearings. From the very first, the hearing produced shocking revelations.

Robert E. Lowry testified that his 76-year-old mother bought 13 different life and health insurance policies from seven agents during a 2-year period, even though the policies cost her more than

$9,000 a year or 68 percent of her annual income. Mr. William Grubb, a vice president for Bankers Life and Casualty (which the seven agents represented) told the committee that Mrs. Lowry's case was not typical. "Frankly, we're embarrassed," he said. He added it is difficult for a large company to control the activities of all its agents and that the unscupulous agent in this case had been forced to resign.

W.W. Cooper, former administrator of the Florida Insurance Department, entered in the record a similar letter sent by an elderly couple, ages 82 and 78, who delayed repairing their refrigerator, television, or stove because they were trying to keep up a $2,882 annual premium on 19 separate insurance policies. Cooper said that the problem in Florida was under control and that most of the unscrupulous agents had been driven out of the State.

Another example related at the hearing concerned a 79-year-old farmer from Ohio who had been told by one salesman that the Federal Medicare program was broke as a justification for selling the man more insurance, allegedly to protect him against catastrophic illness.

Jules Klowden, an insurance consultant with a San Diego, CA, senior citizen center described many Medicare supplemental insurance policies as junk policies which offer no benefits (but) can bankrupt a family.

After the first day of hearings, the members of the committee were greatly distressed. Senator John Glenn talked about the abuses in terms of the economic rape of the elderly. "This has got to be a real flimflam—a real fraud situation," he said. Ranking minority member on the committee, Senator Pete V. Domenici, said, "The elderly are becoming a new and expanding market for the unscrupulous. Senior citizens are often lonely and want someone to talk to (and) insurance agents know this."

Former Wisconsin Insurance Commissioner Harold Wilde provided the committee with testimony in the form of a summary of his December 1977 speech. He also provided the committee with its best suggestions for reform. He said he was generally wary of Federal intrusion but welcomed Federal interest here because "there is a Federal moral responsibility" and for "practical reasons." He said the Federal Government created the Medicare Program and its gaps and the problems left in its wake.

Weekly Review is an independent newspaper for senior citizens in the Chicago area. During early June of 1978, they published an investigative piece under the byline of Editor J. Ram Ray. The newspaper expose focused on Medicare supplemental insurance ripoffs.

In July 1978, Kansas Insurance Commissioner Fletcher Bell discovered serious abuses in the sale of Medicare supplemental policies in his State, so much so that he called together the companies specializing in such sales in the State and warned them not to continue preying on the elderly. Among the cases turned up in what Bell called his preliminary investigation were the following:

> An elderly woman was sold 11 policies by one company in the last 3 years with three currently in force. Total premium payments over the period were in excess of $2,500.

Bell said that some Kansas residents have been sold as many as two dozen policies providing unneeded or duplicative coverage. He said that many senior citizens are victims of loading and switching. The sales of multiple policies to one person is called loading, he said, while switching is the practice of lapsing an existing policy and the sale of a new one because the agent receives a substantially larger commission on the sale of the new policy than on the renewal of the existing policy.

As a result of the investigation, one company was fined $5,000 and five agents were brought forward on license revocations.

As summarized in the Los Angeles Times, the 1978 FTC report said that one quarter of the elderly Americans who annually spend $1 billion for extra insurance to cover Medicare gaps actually buy unnecessary, costly and overlapping coverage.

The report said that lack of consumer information, unscrupulous sales tactics by some firms and a lack of uniformity in policies had created considerable confusion among consumers and caused higher health costs for elderly persons living on fixed incomes. The report also picked up on Commissioner Wilde's suggestion that the Federal government must address the problem since the problem had its genesis in the enactment of Medicare in 1965.

Commenting on the FTC report, Congressman James Florio, a member of the House Aging Committee, said, "The elderly are ripe victims of unscrupulous insurance salesmen. Since the advent of Medicare, an apparent need has developed to cover what Medicare does not. However, we did not foresee the potential for health insurance fraud that occurred as a result of this gap in coverage."

On July 19, 1978, Congressman Claude Pepper wrote to the Postmaster General of the United States asking for any further experience with insurance fraud and abuse in the files of the Postal Service. Listed below are typical or current cases involving alleged mail fraud in the sale of insurance. The Postal Department commented:

> Elderly persons in many cases tend to be timid and trusting, to be unsophisticated in the ways of confidence men, and to be vulnerable to the blandishments and high pressure tactics of dishonest promoters. It is an unfortunate fact, and a commentary on the heartlessness of these fraudulent operators, that an elderly person once victimized derives no immunity thereby from further exploitation. He or she may well be added to a list of proven easy marks to be targeted again by the same fraudulent operator or his associates.
>
> Our investigations are initiated in the usual case upon receipt of complaints from victims of an ongoing scheme. For the person who has already been defrauded, investigation and prosecution of the operators of the scheme are after-the-fact events unlikely to benefit him personally. Restitution of the money lost is improbable. Closing down the operation and prosecuting the operators does, however, assure that others will not be victimized by the same scheme.

The Chicago Tribune Task Force published a hard-hitting series on the problems of the elderly beginning the third week of Septem-

ber 1978. One segment of the series which was especially powerful was headlined, "Insurance Firms that Feast on the Fears of the Aged." In the course of preparing the report, Tribune reporter Bill Gaines worked as a trainee with insurance companies in Tennessee and Illinois. In using this technique, Gaines was able to obtain firsthand information on the operations of several companies that specialize in the sale of Medicare supplemental policies. He found some companies and their salesmen scrupuluously honest. Others were less so.

In addition to posing as a trainee with insurance firms, Gaines examined records which showed that some insurance companies are returning less than 30 cents on the premium dollar in benefits for health insurance.

The Tribune reported that records in the Tennessee Department of Insurance shows that only 22.7 cents of each dollar a person that State pays for accident and health insurance is returned in benefits by the company.

The Tribune reported that Gaines later took a trainee position with an agency whose agents traveled from town to town in rural Illinois working out of motels. They got leads on prospective customers from the Illinois Association of Senior Citizens, a not-for-profit corporation with 30,000 members that operated from a basement office in Peoria.

The Tribune reported that, "Last year * * * the insurance company Gaines worked for * * * paid more in commissions to salesmen than in benefits to policyholders according to official reports filed with the Illinois Department of Insurance: 37 cents on the dollar to policyholders and 38.2 cents to salesmen.

In November 1978, the House Select Committee on Aging, chaired by Congressman Claude Pepper (D-Fla.), held hearings and released an exhaustive report entitled "Abuses in the Sale of Medicare Supplemental Insurance to the Elderly in Supplementation of Medicare: A National Scandal." The committee called the problem a national scandal of staggering dimensions. Testimony revealed that some insurance companies and their unscrupulous agents had become merchants of fear. "Capitalizing on the anxiety about ever-escalating health costs, they have conspired to sell senior citizens multiple, unneeded, duplicative and therefore, essentially worthless insurance policies in supplementation of Medicare, the national health insurance program for the elderly."

A 444-page committee report, "Abuses in the Sale of Health Insurance to the Elderly: A National Scandal," estimated that senior citizens were being taken for as much as $1 billion out of the $4 billion they spent for Medicare supplemental policies each year.

The committee found that it was not uncommon for senior citizens to have 3, 5, 10, 30 and in one instance 91 different insurance policies. In the most blatant example to come to the committee's attention, a 76-year-old Illinois woman paid over $50,000 in insurance premiums over 10 years and was forced to remortgage her farm to keep up with the premiums.

Both the 1978 hearing and its study zeroed in on the pervasive abuse in insurance policies that claim to supplement Medicare. The study was the first detailed national investigation of this problem. It represented the first time that every State department of insur-

ance and the great majority of companies selling Medicare supplemental insurance policies to the elderly had been surveyed. For the first time, large numbers of senior citizens had been asked about their problems with such policies. In addition, the committee conducted investigations in nine States and the District of Columbia:

For example, Margaret Dickson, one of the committee's senior citizen investigators, got some unsettling advice from health insurance agents when she asked them to look over her collection of supplementary policies for Medicare.

Mrs. Dickson was overinsured, but most agents insisted that she buy even more coverage. Some dismissed her policies as garbage without even looking at them, and pressed her to replace them with as many as eight new overlapping plans. Mrs. Dickson said one agent grilled her about my tax bracket, my banks, my general financial situation, and then suggested—oh heavens, I cannot say it—euthanasia as a solution to long-term health problems. He also asked her to give him power of attorney over her affairs.

What these agents didn't know was that Mrs. Dickson, a retired receptionist for the committee chairman, was working with congressional investigators. Her son, who took photographs of the meetings, and the insurance sales trainee sitting in on them were committee investigators.

In 50 such inteviews, conducted during the fall of 1978, only eight agents honestly advised, "Gee lady, I think you've already got too much insurance."

Mrs. Dickson's case was not unique. Investigators found widespread misrepresentation of what policies pay for, high-pressure sales tactics, agents posing as Federal employees, agents persuading elderly persons to replace adequate policies with new ones just so the agent could get a higher commission, and companies that paid out very little in benefits compared to the large amounts they collect in premiums.

In addition, the report detailed the activities of four staff investigators who obtained jobs with insurance companies in order to determine whether the abusive marketing practices were company policy.

A 1978 study by Chairman Claude Pepper, House Select Committee on Aging, concluded that there were widespread abuses with respect to so-called Medigap insurance policies and the manner in which they were sold to the elderly. It also concluded that there has been failure to aggressively regulate such abuses by many State Insurance Commissioners. The study likewise concluded that most major insurance companies are not involved in the abuses which filled the report.

The abuses that were found were among the insurance companies who specialized primarily in the sale of individual policies. Even then, the most serious problems were generally found among the small and almost anonymous insurance companies that specialize in selling to the elderly.

Following the investigations and hearing by the House Select Committee on Aging, Chairman Claude Pepper introduced H.R. 2602, a bill to curb the proliferation of abuse in the sale of Medigap insurance. The bill, which enjoyed the cosponsorship of 265 Members of Congress, would:

Establish a program of voluntary certification whereby these policies which meet or exceed Federal minimum standards could be awarded a Federal seal of approval by the Secretary of Health, Education and Welfare.

Make it unlawful for insurance agents to indulge in two common abuses: overselling and the government look. There were no laws prohibiting an agent from deliberately selling seniors more insurance than they need or pretending to be representing the Federal Government or from using advertising materials displaying the Federal eagle and giving the appearance of an official Government document. These practices would be outlawed under the bill.

Help the States regulate mail order insurance. Under current law in 1977, the States could not effectively regulate Medicare supplemental insurance sold through the mail. The proposal would require mail order Medigap firms to first file their policies with the commissioner of insurance in the State in which it would be sold and obtain his or her approval before they could mail their policies into that State.

The introduction of H.R. 2602 stirred up a strong lobbying effort against its enactment by opponents in the insurance industry. Even with strong bipartisan support for the reform legislation in the House, efforts to move the bill swiftly through the House were stalled by intensive lobbying forces. Staff of the House Select Committee on Aging met with staff of Senator Max Baucus (D-Mont.) and then Senator John Culver (D-Iowa) to seek support for movement of the bill in the Senate. Both Senators agreed to introduce S. 1295, a bill identical to Chairman Pepper's H.R. 2602. Between December 5, 1979 and January 30, 1980, Baucus redrafted his bill to exempt from the certification program health insurance contract established by employers or labor organizations. Baucus also went along with an amendment making clear that effective State programs could replace Federal certification.

The Baucus bill had strong political appeal and was adopted as an amendment to a Social Security disability bill approved by the Senate on January 30, 1980. The House passed its version of the Baucus amendment May 22, 1980. And, on June 9, 1980, the voluntary certification of Medicare supplemental health insurance policies became Public Law 96-265. Among other things, the new law required that a program of voluntary certification for Medigap policies be established; the overselling and the government look as insurance practices be outlawed; that mail order firms be required to first file their policies with the commissioner of insurance in the State in which the policy is sold; and that a study of State regulation of such insurance be undertaken by the Department of Health and Human Services.

On January 15, 1979, Business Week, noting that heart disease kills far more people than cancer, stated that there is tremendous fear of cancer in American society. It continues:

> Cashing in on this fear is the obscure but increasingly controversial American Family Life Assurance Co. of Columbus, GA, which 15 years ago became the Nation's first marketer of insurance policies that cover the expenses of

treating cancer. Even though as many as 300 insurance companies—mostly smaller ones—offer similar coverage, 60 percent of all cancer policies in force have been written by American Family.

With the company's success in cancer insurance has come a measure of notoriety. Increasingly, critics both within the industry and outside the insurance fraternity, such as State regulators, consumer groups, and even representatives of the National Cancer Foundation, are damming cancer insurance. These opponents argue that it is little more than a mercenary exploitation of public fear, and that it is a bad buy, offering only paltry benefits for the cost.

Most of the country's big life insurance companies, which as a rule also offer accident and health programs, do not sell cancer policies. These insurers contend that people are better off under a more comprehensive health plan covering all other diseases and cancer. "If a person buys cancer insurance, he's only partially covered," says Alan N. Ferguson, vice president and actuary for Prudential Insurance Co. of America. "It's like insuring only part of your house against fire."

Far harsher was the condemnation by one executive with a major insurance company, who declares: "American Family is selling garbage. And they're making a lot of money on it. Their appeal is to the fears of people—pure and simple."

Business Week added:

Some State insurance watchdogs charge that another key to the success and profitability of the cancer marketers is that too little is paid out in benefits. "When you end up with multiple policies, you're usually paying what amounts to duplicate premiums for too little coverage," says Peter Kelly, director of financial and regulated affairs for the Connecticut Insurance Department.

"I have never seen a specific disease policy with a high loss-ratio (benefits paid related to premiums collected)," says one state insurance commissioner. "I am deeply concerned about cancer insurance, because I believe it is sold by people improperly using high-pressure tactics without sufficient disclosure about the product."

A June 11, 1979 Washington Post article entitled "Cancer Insurance Coming Under Increasing Attack" contained the following:

Barely 7 weeks after the nuclear accident at Three Miles Island powerplant, Mutual of Omaha began an intensive sales campaign in the Harrisburg, PA area for what has become one of its hottest selling products: cancer insurance.

You kind of hate to capitalize on something like that says a Mutual sales manager in Harrisburg, who nonetheless confirms that his agents went door to door warning

residents there that they may risk cancer because of radiation that leaked from the powerplant.

During a June 13, 1979, hearing by the Subcommittee on Health and the Environment, House Committee on Interstate and Foreign Commerce, Congressman Claude Pepper, chairman of the House Select Committee on Aging, testified about his bill, the Senior Health Insurance Reform Act of 1979.

At that hearing, a colloquy took place between Chairman Pepper and Congressman Andrew Maguire. Congressman Maguire said:

> I have one other question about cancer policies. I notice that you have gone into that in the staff study, particular with some work in the State of Maryland, and I note that New Jersey is one of three States that has legislated against cancer policies or other dread disease policies, which really are another way of victimizing people and preying on their fears and their suffering, because these policies, like the one you described for Medigap coverage, simply do not do the job. People pay enormous amounts of money for almost no coverage that would ever be available to them, or if they got cancer, that would give them any coverage that was worth talking about * * *. I am just wondering if we need to do something additional. What does the bill do now about the dread disease policies, the cancer policies, which are not being sold, I understand, to people in the Harrisburg area after the nuclear accident there, door to door? They are selling these people policies which they think will somehow protect them against cancer or pay for cancer if they get it. Of course, neither of these things is true.

Chairman Pepper answered:

> We are in a dilemma—those of us who want to protect these people are in a dilemma. Heretofore, Congress has enacted legislation against Federal Government regulation of insurance company operations on the theory that it is a matter that ought to be handled by the State. Now we find a flagrant lack of action of the proper character by the State, so we are looking around. What do we do? Do we reverse our previous abnegation of authority that we could assert, of the Federal Government regulating insurance, having to grant licenses, revoke licenses, police the operations of these companies and all that?
>
> Or do we just do sort of the best we can to try to exert a wholesome Federal influence?
>
> This bill is a very minor step in the right direction; at least it offers a hope that there will be some persuasive leadership given by the Federal Government to the States.
>
> Your distinguished committee, if it were to approve this legislation, I am sure would have language in a report that would encourage the State to take the prime responsibility for that matter. This is a mild and a very timid beginning, but it is a beginning, and it does tend to protect people.

> Take these cancer policies. I can't believe that the Department of HEW would approve these cancer policies that we have had presented to our committee. We intend, of course, that cancer policies be included in our bill.

On June 17, 1979, the Philadelphia Bulletin ran a story by Stephen Franklin which described new State regulations which took effect on July 24 requiring insurance firms to provide minimum coverage benefits. The effect of these regulations is to strongly discourage the marketing of cancer insurance. The report began:

> It's a sales pitch fed by fear and uncertainty.
>
> If cancer strikes, where will you get the money you'll need for hospitalization * * * radium, cobalt, chemotherapy (drug treatment) or x-ray therapy asked an advertisement placed in 12 Pennsylvania newspaper last week by a King of Prussia insurance firm.
>
> Don't be one of those who refuse to face the frightening facts of cancer, warned the ad from World Life and Health Insurance Co.

The article continued:

> On the surface, cancer insurance has appeal.
>
> It is cheap, generally costing between $50 and $150 a year. It is usually easy to get, and most companies selling it promise to pay the steep medical bills associated with cancer treatment.
>
> But not everyone considers it a bargain. Its critics, including some State and Federal officials, have wondered if it is any better protection against the high costs of cancer than an umbrella against a hurricane.
>
> They say the policies, often sold through fear or high pressure sales tactics, are close to worthless because of too many limitations and restrictions that leave hospital and doctor bills unpaid.

The story quoted Robert Reich of the Federal Trade Commission as saying:

> The coverage is not good at all. And the companies are making a large amount of money. Cancer insurance is really an embarrassment to the industry.

In June of 1979, the National Credit Union Administration, the Federal agency established by Congress to oversee the operations of credit unions, began an investigation of cancer insurance given evidence that many credit unions were sharing their mailing lists with cancer insurers. It appears that the credit union would receive a percentage of premiums paid on each policy as their share for this cooperation. Often the fee is billed not as a commission but as administrative expense—a convenience perhaps to avoid violation of State laws which say that commissions cannot be shared with unlicensed individuals.

On June 24, 1979, Lawrence Connell, Chairman of the Administration, made a tough speech before the Credit Union Executive Society. He said in part:

> Among new areas of cancer at NCUA is the sale of cancer insurance and other group buying plans * * *. It would be the most egregious affront to credit union principles to endorse or to recommend a service to members that preyed upon their deepest fears. At NCUA, we will be studying sales of cancer insurance and other products which are endorsed by leagues. We have heard rumors that attractive commissions have been a common sales technique. Federal credit unions are prohibited from receiving reimbursement in excess of their administrative costs. We will enforce that regulation so there will be no direct threat to the integrity of their operations. However, we do have a concern about indirect compromise.
>
> We will conduct a study of insurance services sold to members through their credit unions.

On June 13, 1979, Chairman Pepper released a report by the U.S. General Accounting Office which was asked to analyze the economic value of various dread disease and other Medicare supplementary health insurance policies. Part of the reason for Chairman Pepper's request to GAO was due to confusion about accurate loss ratio figures for various companies selling cancer insurance. Following are highlights from GAO's report:

> Loss ratio is the proportion of gross premiums which, on the average, is returned to policyholders in the form of benefits. As such it is an indicator of economic value of a policy form or forms offered for sale by an insurance company. Loss ratios are usually expressed in percentages. For example, if the loss ratio for a year (or other specified period) were 55 percent, this would mean that total benefits paid to policyholders—for illnesses originating during the period—would amount to 55 percent of the premiums which they had paid.

Moreover, although the loss ratio is used as a measure of economic value, it does not reflect other factors which should be considered in determining economic value such as:

> What other insurance is available covering the same illness or other contingency?
>
> Is the individual's financial situation such that he/she can reasonably afford to buy the insurance?
>
> If an individual has other insurance covering the same contingency, will benefits payable on the new or an existing policy be reduced accordingly under a provision for coordination of benefit?
>
> GAO noted that the National Association of Insurance Commissioners suggested an accepted loss ratio guideline of 40 to 65 percent for health insurance policies issued to individuals and a minimum of 60 percent for policies sold in supplementation of Medicare.
>
> GAO determined that the following were accurate "aggregate actual loss ratios" for cancer insurance policies issued by the companies named below:

	Number of policy forms identified	Premiums earned (millions)	Losses incurred (millions)	Loss ratio (percent)
Union Fidelity Life Insurance Co., Trevose, Pa.—1976	9	[1] 4.8	0.9	[1] 19
Libert National Life Insurance Co., Birmingham, Ala.—1977	14	21.3	5.5	26
American Family Life Assurance Co., Columbus, Ga.—1977	[2] 8	152.6	64.9	43
Colonial Life and Accident Insurance Co., Columbia, S.C.—1977	5	5.2	2.5	49
Lone Star Life Insurance, Co., Dallas, Tex.—1977	3	9.9	5.5	55

[1] 1 policy form accounted for $4,500,000 or 94 percent of the $4,800,000 in total premiums earned on the 9 policy forms. This policy form reported $3,200,000 in premiums earned for the 1st year with a loss ratio of 13 percent, and $1,300,000 in premiums earned for renewals during 1976 with a loss ratio of 37 percent.

[2] This number does not include policies no longer issued which the company grouped together for reporting purposes. Of the total premiums earned, $1,600,000 is applicable to these policies.

In June 1979, the Senate Banking Committee opened an investigation of cancer insurance in the face of significant evidence that not only credit unions but also major oil companies and banks through their credit cards have been offering cancer insurance.

On August 28, 1979, the Wall Street Journal quoted Robert Reich, Director of the Office of Policy Planning and Evaluation of the Federal Trade Commission, who said:

> There is evidence that many companies selling cancer insurance are preying on the customer's fears of cancer through the use of scare tactics.

The Journal noted criticism from established health insurers:

Buying a cancer policy alone, instead of a comprehensive insurance plan, is like "insuring a ship against fire but not against sinking," says Thomas, A. Harnett, senior vice president and counsel of Travelers Insurance Co. of Hartford, CT.

On September 18, 1979, the Massachusetts Department of Insurance banned the sale of cancer insurance and referred several cancer insurers to the attorney general for possible legal action.

A report—chronicling the most in-depth investigation of cancer insurance ever undertaken by any State—was issued. Among its recommendations was a complete ban on cancer insurance.

In banning cancer insurance, the department decided this coverage is often uneconomical, duplicative of existing health insurance, and sold on misleading terms.

The practical effect of the regulation is that any company which wishes to sell dread disease insurance must cover a broad range of such diseases—such as heart disease, various kinds of paralysis, chronic lung diseases and severe burns or fractures—and not simply cancer.

Such broad-based dread disease and accident insurance cannot be cancelled before an individual reaches age 65 and may be marketed only to individuals less than that age to prevent salesmen from preying upon the fears of the elderly who are considered adequately protected by a combination of Medicare and Medicare supplemental insurance.

In its December 1979 issue, Changing Times carried a story entitled, "Why Cancer Insurance is a Bad Buy." The story begins:

> The sales letters pull no punches. "Cancer is so horrible and dreaded a disease that the normal reaction is to say, 'It can't happen to me' " Yet, the "odds are very high that someone in your family will be stricken * * * so you must

> protect yourself and your family from the crushing costs * * *. Most people's financial resources are no match for the overwhelming costs of today's treatment."
>
> In part because of such scare tactics, the selling of cancer insurance, which pays off for that disease only, has become one of the fastest-growing businesses in America—even though few major insurers offer it and an impressive array of critics advise against buying it. They charge that insurers are exploiting fear and ignorance to market policies of dubious value.

In March 1980, the House Select Committee on Aging held a hearing and issued a report entitled, "Cancer Insurance: Exploiting Fear for Profit." The major findings and conclusions of this hearing and report follow:

(1) Some companies sell disproportionate number of cancer insurance policies to the elderly.

(2) Some companies improperly imply an endorsement for their product from the American Cancer Society.

(3) Most insurance companies which sell cancer insurance use scare tactics to induce people to buy policies.

(4) Some companies exaggerate statistics to promote cancer insurance.

(5) Companies selling cancer insurance belabor cancer costs.

(6) Companies selling cancer insurance belittle basic health insurance coverage.

(7) Many companies selling cancer insurance mislead the consumer by misrepresenting or exaggerating the benefits of their policy.

(8) Some cancer companies falsely imply an association with the U.S. Government.

(9) Some cancer insurers use phony testimonials.

(10) Some companies sell cancer policies falsely claiming that they are cheaper group plans when they are really individual policies.

(11) Some cancer companies make phony promises that a patient will be paid twice for the same illness.

(12) Companies sometimes sell polices which have not been approved by the State.

(13) Some companies reduce benefits so that the policy the consumer receives provides less coverage than the one they bought.

(14) Some companies say their policies are guaranteed for life and that rates won't increase. However, rate increases are instituted nonetheless.

(15) Companies selling cancer insurance offer a product which has very limited economic value.

(16) Many people will never recover benefits from their cancer insurance policies because of coordination of benefits contained in their major medical plans such as Blue Cross-Blue Shield policies.

(17) Money spent on the purchase of a cancer insurance policy could be better spent on improving one's comprehensive insurance coverage.

(18) Abuses by agents selling cancer or other dread disease insurance policies are widespread.

(19) Companies selling cancer insurance exercise little control over agents; agents' licensing and training are inadequate.

(20) Cancer policies frequently include uncommon restrictions and limitations.

(21) Cancer policies cover only cancer; with the exception of American Family, most companies imply coverage for other health problems.

(22) Although most cancer costs are incurred outside the hospital, cancer policies unfortunately are geared to pay for cancer costs only when the individual is in the hospital.

(23) Although cancer, by its very nature, brings on related medical problems, many cancer insurance policies do not pay for the cost of these complications.

(24) Some cancer policies will pay only for a certain time limit after cancer is diagnosed—a fact which is not always made known to the policyholder.

(25) In order to limit their liability, most cancer insurers won't pay until cancer is diagnosed by a pathologist, which can be a costly or life-threatening procedure.

(26) In cancer policies, what the big printed gives you, the little print takes away.

(27) Cancer insurance policies often employ obtuse legal jargon or other language confuses the consumer.

(28) Many cancer insurers promise mountains of benefit but deliver molehills of protection.

(29) Even the proffered peace of mind that cancer insurers say that they offer is illusory.

(30) Many companies selling cancer insurance have high rates of denial or errors in their payment claims.

(31) There are serious shortcomings in the procedures for resolving complaints among major cancer insurers.

(32) Some State insurance commissioners are lax in their regulation of cancer insurance sold by agents.

(33) Insurance sold by mail, particularly mail order cancer insurance, presents special problem and is essentially beyond the reach of State regulators.

RECOMMENDATIONS

1. The Congress should require that policies sold to the elderly in supplementation of Medicare provide broad coverage and are not limited to providing protection against the cost of incurring a single dread disease.

2. The States should carefully review and upgrade their regulation of cancer insurance with an eye toward providing requisite protections for all Americans.

3. The Congress should act immediately to help the States regulate and close the no-man's land which presently permits mail order firms to sell cancer and other health insurance policies in States where such policies are not filed with and approved by the commissioner of insurance of that State.

Also in 1980, the Senate Judiciary Committee on Anti-Trust and Monopolies, chaired by Senator Howard Metzenbaum, held two

hearings on cancer insurance and took testimony from both private citizens and the cancer insurance industry.

On June 9, 1980, the voluntary certification of Medicare supplemental health insurance policies became public law (P.L. 96–265), based on legislation offered by Senator Baucus and then Senator Culver and Congressman Pepper. Among other things, the new law required that a program of voluntary certification for Medigap policies be established; that overselling and the Government look as insurance practices be outlawed; that mail order firms be required to first file their policies with the commissioner of insurance in the State in which the policy is sold; and that a study of State regulation of such insurance be undertaken by the Department of Health and Human Services.

On January 1, 1982, as required by Public Law 96–265, the Secretary of the Department of Health and Human Services (HHS) was to transmit to the Congress the report of his comprehensive evaluation of State efforts to regulate Medigap insurance. The report was not delivered.

On July 1, 1980, as mandated by Public Law 96–265, the Secretary of HHS was to transmit to the Congress the first in a series of reports on the implementation of the voluntary certification system and criminal penalties established by the law. The report was not transmitted.

On July 1, 1982, the voluntary certification program established under Public Law 96–265 became effective.

In September of 1983, the first of four parts of the comprehensive study of the effectiveness of State approaches to the regulation of Medigap was transmitted to the Congress by HHS Secretary Margaret M. Heckler. The other three reports were said to have been delayed by administrative backlogs. The first component of the study reports the results of a survey of senior citizens and a review of State regulatory environments in six States. Issues covered in the consumer section include: policy ownership; characteristics of policies owned; quality of policies owned; sales abuse; and consumer knowledge. Issues covered in the section on State environments include: quality of policies owned; duplicative coverage; sales abuse; and consumer knowledge.

In February 1984, Congressman Claude Pepper, chairman of the House Select Committee on Aging's Subcommittee on Health and Long-Term Care prepared and sent to all State Commissioners of Insurance a detailed two-page questionnaire designed to ascertain each State's experience in the regulation of Medicare supplemental insurance. The results of that survey are discussed in section IV of this report.

On May 3, 1984, the Chairman of the Federal Trade Commission, Michael Pertschuk, gave testimony before the Subcommittee on Monopoly and Commercial Law of the House Committee on the Judiciary. Chairman Pertschuk issued sharp criticism of the insurance industry. He stated, "Insurance consumers continue to suffer tremendous economic injury on a grand scale from inadequate disclosures, deceptive sales practices, and poor State regulation."

In June 1984, Consumer Reports magazine issued a lengthy report on Medigap insurance. It provided an analysis of a sample of

major Medigap policies and gave tips to consumers interested in purchasing supplemental Medicare insurance.

On June 13, 1984, HHS Secretary Margaret M. Heckler transmitted the Fiscal Year 1981 Medicare Annual Report. This report contained several pages of information relative to Medigap insurance and HHS's activities in implementing the voluntary certification system and criminal penalty requirements of Public Law 96–265. HHS maintained that these pages represented compliance with the report they were required to submit by July 1, 1982, under the Medigap reform legislation.

In the spring of 1986, the Subcommittee on Health and Long-Term Care of the House Select Committee on Aging, chaired by Congressman Claude Pepper, conducted the initial three of a series of hearings on catastrophic health care coverage. The subcommittee heard from Americans young and old across the nation about their personal experiences with the devastating financial and emotional impact of catastrophic illness. Many of the country's leading health policy experts appeared at these sessions, among them former Director of the National Institute of Aging, Dr. Robert Butler; former Secretary of the Department of Health, Education and Welfare Joseph A. Califano; director of the Harvard University Medicare Project, Dr. David Blumenthal; and the head of the National Leadership Council of Aging Organizations, Mr. Jacob Clayman. These and other skilled observers told the subcommittee that senior citizens are left most vulnerable to the devastating effects of chronic illness such as Alzheimer's disease and Parkinson's disease, and long, drawn out terminal illnesses such as cancer. They stated that Medicare and private insurance leave the victims of these catastrophic illnesses unprotected. They urged the subcommittee to make major reforms to the Medicare Program to include long-term care and preventive service coverage.

At the kickoff hearing of the series on February 19, 1986, "Catastrophic Health Care Coverage: Mending a Broken Promise," the subcommittee heard from a Massachusetts man who had been convicted of mail fraud while selling Medicare supplemental insurance to senior citizens. This witness related how he and fellow insurance agents, through an assortment of abusive and deceptive practices, cheated senior citizens hoping to protect themselves against catastrophic illness and the rising cost of health care out of thousands of dollars. He stated that these abusive practices persist today.

On February 24, 1986, Chairman Pepper introduced H.R. 4213, a bill to increase penalties for violations of the mail fraud statute. Under the Pepper legislation current penalties, which have remained unchanged since 1907, would be increased from $1,000 to $10,000 in fines and from 5 to 10 years in maximum jail sentences. In addition, H.R. 4213 grants the Federal Government authority to recoup cash and other assets derived from mail fraud schemes. Many experts feel that this legislation would be a significant step in the fight to combat abuses in the sale of Medigap insurance.

On February 28, 1986, Chairman Pepper introduced H.R. 4287, "Medicare Part C: The Catastrophic Health Insurance Act of 1986." This landmark reform proposal would address the major inadequacies of the Medicare program by offering seniors a new Part C of Medicare which would eliminate all copayments and deductibles

under Medicare Parts A and B, provide coverage of vital preventive services such an eye, ear and dental care and twice-yearly physicals. H.R. 4287 would also provide coverage for long-term care for chronically ill older Americans. This coverage would be provided not through the expenditure of new Federal dollars but by wiser management of current Medicare funds and elderly health care expenditures. The new part C would unite the best of the innovative genius of private industry with a strong Federal quality assurance system.

In March 1986, Congressman Claude Pepper, chairman of the House Select Committee on Aging's Subcommittee on Health and Long-Term Care, prepared and sent another questionnaire to all State commissioners of insurance, to update his 1984 survey. The results of that survey are discussed in section IV of this report.

B. STATE COMMISSIONERS CONFIRM ABUSES IN THE SALE OF MEDICARE SUPPLEMENTAL INSURANCE TO THE ELDERLY (1978—PRESENT)

As is apparent from a review of the chronology of public and private activities relating to abuses in the sale of insurance to the elderly, lively debate and scandals have not been isolated events in the last 20 years. The activities in both the public and private sectors are evidence that abuses are fairly widespread and worthy of a national response for reform. The committee's and subcommittee's investigations involving interviews with agents—details later in this section of the report—add additional evidence to this fact.

During the course of its 8-year-long investigation into abuses in the sale of insurance to the elderly, the subcommittee has managed—with the assistance of insurance agents and State insurance commissioners—to develop a new vocabulary of terms used to describe certain abusive sales tactics. The existence of such terms alone seemed further evidence of the fact that abuses are fairly common. In order to learn if this hypothesis was accurate, the committee and its subcommittee, in 1978, 1984, and again in 1986, included a list of 22 common abuses with its questionnaires to all State insurance commissioners. The State commissioners confirmed that a large number of these abuses were found in every State over the course of the past 8 years.

A list of these common abuses will be found below, followed by a tabulation of the number of State commissioners who indicated that they had evidence of that abuse in their State in 1978, 1984, and 1986.

At the time of publication of this report, 30 States had responded to the subcommittee's 1986 questionnaire. Therefore, the 1986 State response will be reported as a percentage of the States reporting.

Examples of specific instances of abuse are also detailed. Also the examples presented are not exhaustive of the examples reviewed by the Subcommittee, but are illustrative of the abusive sales practice:

Wolf in sheep's clothing.—The agents fails on initial contacts with clients to disclose that he represents a for-profit insurance company. He may say he is from Medicare and wants to help seniors with any problem they may have.

Thirty-four States indicated that they had evidence of this kind of abuse in 1978; 33 reported evidence of such abuse in 1984; and in 1986, 38 percent of the States told the subcommittee they had experience with such practices.

An example follows:

> An Illinois insurance salesman began his sales presentations to several elderly consumers by claiming he was working with a senior citizens association. He told the seniors about ways that they could get discounts on their utility bills. He then pulled out his sales brochure, which he called a franchise health plan. The word "insurance" did not appear on the brochure. He said his corporation was not-for-profit and that his company paid out 142 percent in claims. The senior's trust in the senior citizen association clinched the deal. They, like others, bought his story and his policy.

Pie in the sky (or "fine print").—The agent misrepresents policy content with words like "no waiting periods," "This policy will pay for everything," et cetera.

Thirty-nine States said they had evidence of agents misrepresenting policy provisions in conjunction with the sale of Medicare supplemental and other health insurance policies in 1978. In 1984, the picture had not improved—41 States reported such abusive activity. By 1986, 97 percent of the States reported evidence of such practices.

Several examples follow:

> In Delaware, the wife of a retired colonel in the U.S. Army made 8 different claims on her Medicare supplement policy purchased through a retired Army officers group. These claims included a diagnosis for hypertension, x rays and treatment for a broken foot, treatment for neck spasms, and a claim for bronchitis and possible pneumonia. After paying $1,600 in insurance premiums, she received only $15.25 reimbursement from the insurance company—even after the agent assured her that all of the above conditions would be fully covered under the policy.
>
> An elderly Louisiana woman developed cancer. Her hospital bills came to $747.50. The insurance company paid $112.50, only $24.87 greater than her $87.63 premium. The agent claimed her policy would cover all expenses associated with a bout of cancer.
>
> One agent promised a Midwest family of an Alzheimer's victim that he had the only full-coverage custodial care plan available on the market. However, a reading of the policy indicated that in order to receive this care one had to be in a skilled nursing home. It didn't cover custodial care at all.

The Government look.—Agents and/or companies often use advertising materials that tend to associate them with the Federal Medicare or Social Security programs. Using the above, the agent implies that he is from a Government agency without saying so outright. This activity was outlawed in the 1980 legislation.

Thirty-eight of the States responded affirmatively when asked about having evidence of the existence of this abuse in their States in 1978. By 1984, 38 States again responded that they had evidence

of such abuses; and in 1986, 72 percent of the States reported experience with such abuse.

Examples follow:

A California insurance agent fraudulently induced an elderly woman to apply for life insurance with a well-known company by claiming that the agent worked with the "Old Age Pension," thereby leading the woman to believe it was associated with her Social Security benefits. The agent then tried to get the woman to purchase the policy after she refused by promising to discount the premiums if she paid cash. This is an unlawful rebate in violation of section 250 of the California Insurance Code.

In 1983, the subcommittee received numerous inquiries from concerned seniors nationwide regarding solicitations they had gotten from the Federal Government asking them to purchase insurance to cover increases in the cost of health care enacted by Congress. After reviewing samples of the solicitations, the subcommittee concluded that the envelope suggested that the policy was being offered by the Federal Government. The subcommittee took the matter to the State commission of insurance in the State from which these solicitations originated, for followup action.

Scare tactics.—The agent employs scare language in closing the sale like "Buy now because you may not be able to be insured later," et cetera.

Thirty-eight States said they had evidence of agents using scare tactics in their efforts to sell Medicare supplementary policies in 1978. By 1984, 38 States still said they have evidence of such activity. By 1986, 90 percent of the States reported experiences with such abuse tactics. Examples follows:

An Illinois staff investigator witnessed a salesman telling a woman that because of the skyrocketing costs of a prolonged hospital stay she should buy one of his Medicare hospital supplement policies. Once she acquiesced and signed for the policy, he reached into his bag and pulled out a copy of a hospital utilization review letter that informed a certain patient that she should have to leave the hospital after only 3 days. The agent said, "You know that the Government forces people out of hospitals and into nursing homes." He then told her he had a terrific nursing home policy and attempted to sell it to her using exactly the opposite argument he had used in selling the hospitalization policy.

A professional staff member of the U.S. House Select Committee on Aging obtained employment with an insurance company selling dread disease policies. The presentation she was taught to use to sell such insurance was designed to frighten and upset people regarding the disease and its cost.

Agents of a California insurance company were taught to use high-pressure techniques to close sales, including using dramatic visual aids. One set of drawings showed a man being rushed to the hospital with a heart attack while another showed men begging, borrowing and stealing to try to pay for health expenses because they had not purchased enough health insurance.

Overselling.—The agent sells the clients more coverage than they need or can pay for, or both (also known as "stacking" or "overloading"). If you have two or more policies offering the same benefit, you only get paid once. This practice was made illegal by the 1980 legislation.

Forty-four States reported they had experience with such abuse in 1978. In 1984, 38 States said they had evidence of "overselling." And in 1986, 100 percent of the States responding said "Yes," they had seen examples of overselling.

Duplicate sales.—The agent sells the client additional policies which are in effect duplicate existing policies held by the client.

Thirty-six States said they had evidence of this abuse in 1978. Six years later, 35 States reported such abuse; 90 percent of the States did so in 1986.

Examples of "overselling " and "duplicate sales" follow:

> Frightened that Medicare was not enough, an elderly couple had purchased 13 separate health insurance policies before an investigator at the Michigan Insurance Bureau could stop them from buying more. They were paying $4,000 a year in premiums and still had no coverage for vision, dental, or hearing care, prescription drugs, and other services.
>
> A 76-year-old North Carolina resident was sold 13 health and life insurance policies from one insurance company over a two-year period; she was paying 68 percent of her annual income in premiums.
>
> An 83-year-old woman from Minnesota owned 28 insurance policies when she died. Over her last 5 years, she spent $15,000 on premiums. Yet, none of the 28 policies covered nursing home care, though she spent the last 18 months of her life in a Minnesota nursing home.
>
> A Wisconsin woman purchased 19 policies from six agents at an annual cost of $4,000. Unfortunately, most of the policies were worthless because of the duplication and overlap of coverage.
>
> A Florida couple, ages 82 and 78, neglected repairs on their refrigerator, television and stove because they were trying to keep up a $2,880 annual premium on 19 separate insurance policies.

The add on.—The agent, after selling one policy, includes in the "forms for signature" by the client a second or third policy, stating when asked, "You'll need this too!"

Twenty-five States answered "yes" about add ons in 1978. In 1984, 26 States reported evidence of such activity. By 1986, 50 percent of the States reported the add on.

An example follows:

> The irate daughter of an 87-year-old Californian wrote the subcommittee about nine health insurance policies she discovered in the possession of her father—all from the same agent and from three different companies. There were three indemnity policies, two cancer policies, two service policies, a nursing home policy (which turned out to be an indemnity policy) and a hospice plan. Her father said, "He told me I would need all of these—he called it a package deal. Then he came back and said I should have another 'package' for complete protection."

The daughter urged the subcommittee to look into insurance matters, stating, "My father was spending a lot of money because he trusted that agent's advice. He can't afford all that."

The Medigap bandwagon.—The agent sells the client additional accident or life insurance as if it were part of a comprehensive Medigap plan.

Twenty-nine States responded affirmatively in 1978. In 1984, an identical number of States replied, "Yes." In 1986, 53 percent of the States reported evidence of such abuse.

An example follows:

In New Jersey, an agent for Company C and 16 other companies refused to even examine a prospective client's policies. He saw the name of the company on the outside and concluded they were worthless. He told the woman she needed six different policies. He told her to buy Company C's Medicare supplement plan and Company X's cash hospital benefit plan. He said the two complemented each other. He pulled out Company C's nursing home policy, and then a cancer policy from another company. When he told the woman she needed a burial plan, she shrieked openly. To calm her fears, the agent said, "Oh, you don't like blue. Well, we've got the same thing in green. We call it our Life Plan." With that, he pulled a green brochure from his bag.

The fence post policies.—The agent completes applications in the name of relatives or others, unbeknownst to the victims. This is done to bypass underwriting rules when it is known the victims already have the maximum coverage in effect with a company.

Eighteen States said they had recent evidence of this kind of abuse being perpetrated by agents in 1978. In 1984, 13 States reported such abusive tactics. In 1986, 23 percent of the States said they had experience with such abuse.

Here is one example:

One State reported to the subcommittee instances where agents were selling more insurance than a company would allow to be sold to an individual. They would change the recipient's name from John Robert Doe to J.R. Doe or J. Robert Doe, in order to bypass having the limit checked by computers.

Forgery.—The agent either signs someone's name to the insurance forms or encourages the elderly client to illegally sign the name of the insured's loved one.

Thirty States told the committee in 1978 that they had experience with agents forging signatures or engaging in other illegal activities such as writing fictitious policies. In 1984, 33 States reported experience with such abusive tactics. In 1986, 63 percent of the States responded affirmatively.

Examples follow:

The attorney general of Minnesota, Hubert H. Humphrey III, found during an investigation into the sale of health and life insurance to the elderly the widespread practice of forging signatures on applications for insurance. Such cases of abuse occurred when agents learned that individuals already had the same coverage. The agent merely traced the client's signature as it appeared on their original policy onto another application.

An elderly woman in Sibley County, MI, signed an application and wrote a check in the amount of $448 as premium for 1 year, only to find out that her policy was with another company at a cost of $443 for 6 months.

Another woman in Minnesota mistakenly applied for a health insurance policy which she had previously bought from the same insurance company. Instead of returning her check, the agent and his employer merely traced the signature onto a life policy and pocketed her money.

New is better (twisting or existing policies are garbage).—The agent encourages the client to cancel perfectly good existing policies to sell a new policy which results in additional commission fees.

Some 44 States responded that they had evidence of this violation, ranking it as the most widely reported abuse along with overselling, in 1978. By 1984, 41 States reported evidence of this activity, and by 1986, 93 percent of the States said they had experience with "New is better."

Examples follow:

An agent came to a 83-year-old North Carolina woman's home and asked to see what type of health insurance she had. When she told him that she had Medicare and Blue Cross, he replied, "You don't need that garbage. You need my policy."

In June 1986, an agent reviewed a policy held by a subcommittee senior citizen investigator, told her it was "not health insurance," and proceeded to pitch his policy.

More is better.—The agent represents that his policy, which has a higher premium than the competition, is better simply because of higher premium. He may make inflated claims about the coverage provided by the purchase of several policies. In most cases, such policies contain coordination of benefits clauses which means that only one policy will pay.

Twenty-six States said that they had evidence of this abusive sales technique in 1978. In 1984, 20 States said they had experience with this abuse tactic. In 1986, 57 percent of the States responded in the affirmative.

An example follows:

In Virginia, an agent reviewed the policy of a subcommittee senior citizen investigator and then compared it to his policy. Even though an analysis of both types of coverage revealed almost total duplication, he told her that his was double her annual cost because it was better. He said, "You get what you pay for."

Make the check out to me.—The agent asks that the client make the check out directly to him. The agent then cashes the check and does not report the transaction to the insurance company. No policy issued.

Asked specifically about this variation—the agent absconding with premiums paid—in 1978, 40 States said they had recent evidence of such violations. In 1984, 40 States said they had recent evidence of such violations. In 1984, 39 States reported such violations. By 1986, 87 percent of the States reported evidence of such illegal activity.

Examples follow:

A Buffalo, NY, insurance agent swindled more than $100,000 in phony insurance annuity policies. He would convince his elderly targets to drop their existing policies in favor of his company's. He would then pocket the premiums but never send the applications to the insurance companies.

A Massachusetts woman had 25 health insurance policies, the annual premium for which totaled $8,000. Many times, the insurance agent advised her to make the check out to the agent. One of these same agents would later come around to collect the cancelled checks in order that he could not be caught.

Postdating application.—Agent postdates application to avoid maximum coverage guidelines. Net result is that client is often not covered for the initially agreed upon period.

Fourteen States reported evidence of this type of abuse in 1978. In 1978, 19 States said they had evidence of postdating applications. In 1986, 30 percent of the States responded "Yes."

An example follows:

A California agent sold four policies to a couple for the purpose of protecting them from cancer. The agent returned with life insurance policies from different companies—none of them covered cancer. The policies were rejected by the couple but no refund was made until they contacted the California Department of Insurance. There was evidence that the agent altered the date of application on all four policies without authorization from the couple.

Corporate twisting.—A conspiratorial arrangement whereby two or three companies transfer aged customers among themselves. This results in the expiration of policies which are in force, in favor of newly acquired policies with waiting periods.

Twelve States responded affirmatively to the above described abuse in 1978. In 1984, 11 States reported experience with such activity. By 1986, 17 percent of the States said they had encountered problems with this abusive sales techniques.

An example follows:

Four insurance salesmen in Massachusetts were convicted after defrauding elderly citizens of over $100,000. These four salesmen worked together by exchanging names of vulnerable victims who were easy sales, and alternating visits to those people to maintain a fresh face sales approach. The victims were sold thousands of dollars' worth of unnecessary insurance.

Clean sheeting (or failure to report material condition).—The agent fails to report preexisting health conditions of clients to company, ultimately leading to a preexisting condition disqualification of coverage when claims are filed.

Forty-one States answered affirmatively when asked whether they had evidence of agents engaging in this abuse in 1978. In 1984, 40 States still said they had experience with clean sheeting. And, by 1986, 97 percent of the States reported in the affirmative.

Examples follow:

A diabetic man who had taken out a cancer insurance policy contracted cancer and was forced to stay in the hospital 10 days. The company refused to pay for more than 4 days, argu-

ing that he would not have been in the hospital more than 4 days if he were not a diabetic.

Five salesmen under the guise of several insurance agencies defrauded 100 elderly residents of Massachusetts and Maine out of $200,000 by falsifying health histories, overcharging insurance premiums, and misrepresenting insurance products.

An agent sold a policy by telling a senior citizen with a preexisting heart condition that the insurance company would cover up to $1,200 for heart surgery, although in fact the preexisting condition would preclude the senior citizen from coverage for that ailment entirely.

The switch.—The agent sells the client one policy but then switches and provides another for signature at the time of closing.

Twenty-five States responded affirmatively when asked if they had evidence of this abuse in 1978. In 1984, 17 States told the subcommittee they had evidence of such abuse. And, in 1986, 43 percent of the States reported that they were aware of such activity.

Examples follow:

An Arizona agent deceived an elderly couple by wrongly telling them that their current insurance company had changed its name in an attempt to swindle them out of the money they thought they were spending to renew a legitimate policy.

In Iowa, an agent switched companies. One of his clients, who wished to stay with his original company, gave the agent in question a blank check, which he filled out to his new company, never telling the woman.

Just dropped by.—The agent comes by for a visit, perhaps to collect the premium or drop off a new claim form, all the while intending to sell more insurance.

Twenty-nine States responded positively in 1978; 32 in 1984, and 77 percent of the States in 1986.

Examples follow:

An elderly woman living in southeastern Idaho was called on by two insurance agents periodically and unannounced over a period of approximately 6 months. Later it was discovered she had paid close to $9,000 for policies she didn't need but felt obligated to purchase after spending time with these agents.

An elderly woman from northern Idaho had four agents working out of the same insurance agency call on her to visit repeatedly, for a period of 12 months. During this period, they wrote policies through several different insurance companies. By the time the agents were discovered, she had paid out over $11,000 in premiums.

Members of a Texas investigation on Medigap fraud discovered that a number of agents use hit lists in identifying and locating aged victims who are individually known to be susceptible to repeated health insurance sales. Among the many examples they provided was an 84-year-old woman who paid out at least $15,000 for 23 health insurance supplemental policies over a 2-year period.

Group policy.—The agent represents the policy as a group policy with the implication that premiums are less, when in fact there is no group and the policy is the same in coverage and premium as a regular policy.

Twenty-one States said they had evidence of this kind of abuse in 1978. By 1984, 17 States reported evidence of such abuse. And, in 1986, 47 percent of the States replied affirmatively.

An example follows:

> An elderly gentleman from Vermont wrote the subcommittee in 1985 and attached a copy of his health insurance policy. He asked the subcommittee if this policy was one senior citizens buy, because that is what his agent told him and that convinced him to drop the Blue Cross/Blue Shield policy he had held since his retirement. The subcommittee found the policy not only not to be associated with a senior organization but also less comprehensive than the insurance he had dropped and couldn't recover.

The stall.—The agent delays in delivering the policy, which is not effective until delivered, thereby exposing the client to the risk of loss of coverage. Another variation is the delay in responding to the requests of a newly insured person to discuss cancellation of policy. Time limits for cancellation are thereby exceeded.

Twenty-seven States said they had evidence of this abuse in 1978; 6 more States, for a total of 33 States, reponded affirmatively in 1984, and in 1986, 70 percent of the States responded "yes."

An example follows:

> An elderly gentleman from Louisiana wrote the subcommittee to urge the Congress to do something about insurance companies. He said he bought a policy and was told he could look at it before he decided to keep it. After giving the check to the agent, he waited 2 months before the policy arrived in the mail. Upset about the delay and deciding he didn't want to deal with a company that was slow in delivering a policy, he sent it back and asked for a refund. A form reply was received explaining his right of cancellation had expired and a rebate would not be possible.

Low weekly rates.—The agent quotes premium prices on a weekly basis but closes and sells on an annual basis.

Fifteen States responded affirmatively in 1978. In 1984, that number had increased to 17 States responding "Yes." By 1986, 25 percent of the States reported evidence of such abuse.

Examples follow:

> An agent told a subcommittee senior citizen investigator that his policy would only cost her about $177 quarterly—and then proceeded to tell her it would be better to make an annual payment because a discount would apply. He added, "It sounds expensive, but it's cheap when you need to use it."
>
> In 1978, a committee investigator was told by a company representative selling insurance, that, "If you can't afford $5 a month, then you certainly can't afford cancer, can you?" This same sales pitch resurfaced in D.C. in 1986, when an agent told a subcommittee senior citizen investigator who mentioned to the agent she liked to pay monthly premiums because she didn't want to die and have paid more than she should have for insurance. He replied, "Well, if you are that concerned about limiting your financial investment for health security, I am not sure you need to talk to me. Health is a long-term investment."

I work with.—The licensed salesman allows an unlicensed person to front for him.

Twenty-eight States said they had evidence of this brand of illegal activity in 1978. In 1984, an identical number of States reported such activity. And, 1986, 70 percent of the States said they encountered such abuse.

An example follows:

> An agent in Massachusetts told subcommittee staff it was common practice for him to call a friend to present a policy for him if he were busy or tired. Even though the friend wasn't licensed and had no insurance experience, it didn't matter to the agent. He would advise the friend to simply chat with the elderly person and get him or her to make out a check. It always worked, he said.

C. SUBCOMMITTEE INVESTIGATIONS CONFIRM ABUSES IN THE SALE OF MEDICARE SUPPLEMENTAL INSURANCE TO THE ELDERLY—1978 AND 1986

In looking for another way to learn to what extent insurance salesman engaged in assorted abuses, it was concluded that observing actual sales presentations was essential. This conclusion was reached by the subcommittee in the course of its 1978 inquiry into abuses in the sale of Medicare supplemental insurance to the elderly, and again toward the end of its ongoing eight-year investigation into insurance frauds in 1986. The following summarizes the findings of the subcommittee's 1978 and 1986 experiences in actual sales presentations.

THE 1978 COMMITTEE EXPERIENCE USING SENIOR CITIZENS AS TEMPORARY INVESTIGATORS

In mid-year 1978, Margaret Dickson, age 67, and former receptionist in the office of Congressman Claude Pepper was the first senior citizen to be recruited by the House Select Committee on Aging as a temporary investigator. She reacted enthusiastically. Mrs. Dickson was covered by Medicare. In addition, she had supplementary coverage from Blue Cross/Blue Shield, Physician's Mutual and several policies from AARP through the Colonial Penn Insurance Co.

In other words, Mrs. Dickson was already overinsured. She had overlapping and duplicative coverage and was spending far more than she needed to for insurance.

The question the committee sought to answer was what would insurance salesmen do when confronted with a 67-year-old woman who said she needed advice about health insurance. How many would do the ethical and honest thing and tell her she already had too much insurance and then leave?

With Mrs. Dickson, staff members made calls inviting salesmen to visit her. The staff members were careful not to make representations that Mrs. Dickson wished to purchase new policies, but said simply that she wanted advice to see if she were adequately covered. In all instances, subcommittee staff told prospective agents on the phone, before the interview was scheduled, that she was already insured and described the policies which she currently held.

On that basis alone, a number of agents declined to pay a visit and informed committee staff that Mrs. Dickson was already adequately covered. Unfortunately, less than 10 percent of all calls placed by the committee staff in arranging such interviews resulted in such a response. Ninety percent arranged to meet with Mrs. Dickson knowing what insurance she had. When insurance salesmen arrived, Mrs. Dickson presented her policies and asked for advice. Two committee staff members were present in the room with Mrs. Dickson. One took notes and the other openly photographed each visit.

A 1980 article in the Congressional Quarterly summarized, in part, Mrs. Dickson's experiences:

> Margaret Dickson got some unsettling advice from health insurance agents when she asked them to look over her collection of supplementary policies for Medicare.
>
> Mrs. Dickson was overinsured, but most of the agents insisted that she buy even more coverage. Some dismissed her policies as garbage without even looking at them, and pressed her to replace them with as many as eight new, overlapping plans. One agent grilled her about my tax bracket, my banks, my general financial situation, and then suggested—oh heavens, I cannot say it—euthanasia as a solution to long-term health problems. He also asked her to give him power of attorney over her affairs.
>
> What these agents didn't know was that Dickson, a retired receptionist for Representative Claude Pepper, (D-Fla.), was working with congressional investigators. Her son, who took photographs of the meetings, and the insurance sales trainee sitting in on them were Pepper staff aides.
>
> In 50 such interviews, conducted during the fall of 1978, only eight agents honestly advised, "Gee, lady, I think you've already got too much insurance."
>
> Dickson's case was not unique. Investigators found widespread misrepresentations of what policies pay for, high-pressure sales tactics, agents posing as federal employees, persuading elderly persons to replace adequate policies with new ones just so the agent could get a higher commission, companies that paid out very little in benefits compared to the large amounts they collect in premiums.

In time, additional senior citizens were recruited in other States and the same procedures were employed. Among those who volunteered were Edith Podanski of New Jersey, Betty Hamburger of Baltimore, MD, Lillian Teitelbaum of Silver Spring, MD, Amanda Byrd of the District of Columbia, Winona Montgomery and Isador Monger of Phoenix, AZ, Sara Pittman of Macon, GA, and Gladys Adams of Upper Marlboro, MD.

In all, some 50 interviews were held with insurance agents, some of whom represented more than one company. The visits took place in nine States and the District of Columbia. The States were Arizona, California, Delaware, Georgia, Illinois, Maryland, New Jersey, Pennsylvania, and Virginia. Of the agents who appeared, eight were scrupulously honest and did not attempt to force Mrs. Dick-

son and the other seniors to drop existing coverage in favor of their own, or to add their policy to the list they already carried.

On the opposite side of the ledger, the committee staff and its senior citizen volunteers encountered 42 agents, of the total of 50 they met with, who engaged in questionable tactics.

The following are some of the abuses which the committee staff and senior citizen investigators encountered. The 1978 report summarized the following, in part:

1. In Illinois, staff investigators witnessed a salesman telling a woman that, because of the skyrocketing costs of a prolonged hospital stay, she should buy one of his Medicare hospital supplement policies. Once she acquiesced and signed for the policy, he reached into his bag and pulled out a copy of a hospital utilization review letter that informed a certain patient that she would have to leave the hospital after only 3 days. The agent said, "You know that the Government forces people out of hospitals and into nursing homes." He then told her that he had a terrific nursing home policy and attempted to sell it to her using exactly the opposite argument he had used in selling the hospitalization policy.

2. In Georgia, a salesman told Sara Pittman, "You'll want to get rid of this (her Colonial Penn-AARP policy) and you're paying too much for this (her Blue Cross plan). All you need to do is drop these two and pick up our policy and we'll take care of all your health needs."

3. In California, an agent told Margaret Dickson her AARP plan was not good because AARP was under investigation and that there were a lot of complaints about the company—Colonial Penn. He told her to drop her Physician's Mutual policy because it was a mail order policy and of limited value. "You were not the first person to be taken advantage of by mail," he said. He tried to sell her three policies.

4. In Oakland, an agent told Mrs. Dickson her existing policies were of no value. "I would let these go because they are of no value," he said. He said his company was just like Blue Cross/Blue Shield—implying that they were a nonprofit company with the same high reputation as Blue Cross. He pushed two policies.

5. In New Jersey, an agent for 17 companies refused to even examine Mrs. Dickson's policies. He saw the name of the company on the outside and concluded they were worthless. He told Mrs. Dickson she needed six different policies. He told her to buy his Medicare supplemental plan and a cash hospital benefit plan. He said the two complemented each other. He pulled out a nursing home policy, and then a cancer policy from another company. When he told Mrs. Dickson she needed a burial plan she shrieked openly. To calm her fears, the agent said, "Oh, if you don't like blue, we've got the same thing in green. we call it our life plan." With that he pulled out a green brochure from his bag.

6. A New Jersey agent blasted Mrs. Dickson's AARP–Colonial Penn plan. He said he could get into trouble for saying anything about the policy but he was obligated to speak up. He said the plan was lousy. He said the company was under investigation and produced a clipping from the New York Times showing the postal authorities were examining the AARP's use of nonprofit mailing rate. He made reference to the celebrities who sit on this company's

board such as Jesse Owens and Marlin Perkins. He said his company was one of four companies working with the Federal Government to make Medicare work. He produced a brochure quoting Consumer Reports as rating the company's policy favorably with AARP policies.

7. In Maryland an agent told Betty Hamburger that her Blue Cross pl[illegible] was lousy. The company, apparently taking on a sales staf[illegible]er limits it business to mail order. He carefully avoided ad[illegible]. Hamburger to give up either existing policy. Rather, h[illegible]ggested she expand her Union Fidelity hospital coverage, purc[illegible] a nursing home policy from his company and a cancer policy. He used both scare tactics and subtle put downs. "Cancer is a terrible disease. Why wait? The only thing that will change will be your ability to qualify for this policy." The put down: "You may not be able to afford this policy."

8. In the District of Columbia, an agent seemed more interested in obtaining Mrs. Dickson's power of attorney and the right to manage her financial affairs than in selling new inusrance. Once rebuffed for his primary goal, he told her to drop her Colonial Penn and Physician's Mutual policies and to buy one from his company.

9. In Virginia, an agent said she didn't know how people could sleep nights after they oversold insurance to the elderly. She then proceeded to try to sell Mrs. Dickson three additional policies.

10. Also in the District of Columbia, an agent asked all kinds of detailed questions about Mrs. Dickson's financial situation, to the point where she became quite irate. He showed her a brochure which outlined his philosophy, which was a variation of "do unto others." He, too, made a strong pitch for obtaining Mrs. Dickson's power of attorney. He said he knew people at her bank and would try to learn what he could on his own—to help her, naturally. He said her health needs could best be addressed by appropriate estate planning. One idea he had was the professional financial management could help avoid the extremely high cost of long-term care in a nursing home. He suggested giving someone authority so that when death is imminent, life is not prolonged artificially. The man continued to call Mrs. Dickson and ask about her financial matters. He tried to entice her to buy life insurance. As for health insurance, he told her not to let her Colonial Penn or Physician's Mutual policies lapse because she might not qualify for them again.

11. In Arizona, an agent told a senior citizen investigator that his policies pay in addition to all other insurance and recommended the purchase of duplicative policies. He repeatedly claimed that the policy was rated by Best's and that given a choice of buying such a policy or one not rated, you would be a fool to buy any other policy. Finally, he referred several times to an endorsement of his policies by the Arizona Senior Citizens Association. Yet, when questioned, he could not produce any letter of endorsement, the name of any official in the association with whom the endorsement could be verified, or even the city in which the association was located. One local senior citizen leader suspected that the association might exist only as a phony cover for the insurance company itself.

12. Also in Arizona, an agent made false claims about the extent of Medicare's coverage. For example, he told a senior citizen that all Medicare benefits run out in 90 days and thus there was no alternate to purchasing a supplement. In addition, when asked if there was any waiting period before benefits began, he replied that there was none. "Dear, if you get cancer the day after I deliver your policy, and I hope you don't we'll cover you." Yet, the policy describes a one-month preexisting condition clause which directly conflicts with his statement.

13. On November 9, 1978, in Philadelphia, PA, an agent used a number of scare tactics in an effort to sell Lillian Teitelbaum additional insurance coverage. He walked into the room, introduced himself and asked, "Do you have a table?" He seemed to want to talk over a table so that, as he said, he could complete this form he had with him. The first question on the form, after the usual identifying information, was "How much can you spare each week from your income?" When Mrs. Teitelbaum raised an objection to this first question, he persisted and said, just tell me how much it is and that they they could get back to it later in the discussion. He went on to use a variety of scare tactics which included statements such as: "There are doctors who will stick you; at your age, a lot of people need surgery; doctors' fees are rising every day; if you are hospitalized, quite a few doctors visit every day." The agent also misrepresented on several occasions what Medicare did pay for. In his discussion of Medicare benefits, he said that "we pay all that Medicare doesn't pay." When asked if his policy paid for medicines or in-home nursing care, he said, "No, it would be too expensive, I'm sure you understand why." The agent attempted to sell Mrs. Teitelbaum three separate policies. The first was a relatively standard Medicare supplemental policy, the second was a hospital income plan which paid $20 a day for each day in the hospital, and he recommended a cancer policy as well. Before closing his sales pitch, this agreessive agent indicated that his father was the vice president of the corporation and he tried to interest David Holton, investigator for the committee posing as Mrs. Teitelbaum's son, in a cancer, a health and a life insurance plan.

On the same day, an agent was invited to meet and talk with Mrs. Teitelbaum. Mrs. Teitelbaum indicated to the agent that she currently had insurance coverage with AARP. The agent said that the AARP plan was "garbage," and he indicated that it cost more than his plan. In arguing why the Medicare supplemental plan was needed, the agent repeatedly pointed out that Medicare will not pay hospital bills after the 90th day. He indicated that seniors need protection against this kind of event. When Mrs. Teitelbaum pointed out that she thought that most individuals who are hospitalized stayed only about 10 days, he said, "You may be right about that." He attempted to have Mrs. Teitelbaum purchase four policies. The first was a Medicare supplemental policy, the second a hospital cash policy, the third a cancer insurance policy, and the fourth a $2,000 whole life policy at an annual fee of $137 per year for the life only. Before closing, the agent rescinded his offers to sell life insurance policies and cancer policies and recommended that Mrs. Teitelbaum simply buy the Medicare supplemen-

tal and the hospital cash policies. His technique was one of simply offering his policies to Mrs. Teitelbaum for her consideration. His approach was far from a hard-sell one.

SUMMARY OF 1978 SALES PRESENTATIONS TO SENIOR CITIZENS

However offensive these practices may seem, it would not be fair to impute the actions of one or two salesmen to the companies with whom they were employed or affiliated. The committee staff had no evidence in most cases that their actions represented company policy. The only point that can be made is that a high percentage of insurance agents from a diverse number of companies were willing to take advantage of a senior citizen. Even then it was questionable if it was a fair test of the premise since two adults were along to chaperone the actions of the insurance salesman. In those few instances where Margaret Dickson was left alone in the room, salesmen were considerably more aggressive. And then, too, Margaret Dickson and the other senior citizens who were used in this test were well off, bright, well educated and knowledgeable about Medicare. Many older Americans with fewer advantages are much easier prey.

THE 1986 EXPERIENCE USING SENIOR CITIZENS AS SUBCOMMITTEE INVESTIGATORS DURING ACTUAL SALES PRESENTATIONS

In early 1986, Lillian Simmons, age 68, formerly of the State of Nevada and now residing in Virginia, was recruited by the Subcommittee on Health and Long-Term Care of the House Select Committee on Aging as an intern and senior citizen investigator during its inquiry into abuses in the sale of health insurance supplementing Medicare. Mrs. Simmons, recently widowed, was very much aware of the problems confronting seniors in their search for health security and reacted enthusiastically to the subcommittee's request for assistance in determining whether marketing abuses currently exist. Mrs. Simmons was covered by Medicare, parts A and B. In addition, she held a policy with the Prudential called AARP's Extended Medicare Supplement Policy. Unlike Mrs. Dickson from the 1978 committee inquiry, Mrs. Simmons was not overinsured. But she did, in fact, possess adequate coverage to supplement the coverage gaps in Medicare parts A and B. She did not have any dread disease, indemnity or long-term care policy. She pays $38.25 a month, or about $460 a year, for her coverage under the AARP plan—well under the $600 a year national average cost for a Medicare supplemental insurance policy. According to Robert Hunter, president of the National Insurance Consumers Organization in Virginia, Mrs. Simmons was adequately insured given here financial means. For an agent to replace or add on to her coverage, he or she should take into account her income to assume a higher premium, her health status, because preexisting conditions she might have would, in most instances, render a new policy ineffective for a specified period of time, and her existing coverage. In sum, according to Hunter, the only honest conversion of Mrs. Simmons' existing coverage that could be recommended by an agent would involve a more comprehensive plan for approximately the same annual premium, which would cover her preexisting condi-

tion, high blood pressure or hypertension, for which she takes appropriate medication.

The question before the subcommittee was what would agents do when confronted with a 68-year-old widow who said she needed advice about her health insurance coverage. Again, given the 1978 experience and reform legislation which followed, would the agents tell here she was adequately covered, given her financial means, and leave?

As with Mrs. Dickson in 1978, the subcommittee staff made calls inviting salesmen to visit Mrs. Simmons. Identical to the 1978 investigation, the staff members were careful not to make representations that Mrs. Simmons wished to purchase new policies, but said simply that she had recently moved to the D.C. metropolitan area from Nevada and was interested in finding out whether she was appropriately insured for health purposes. The staff would describe the policies which she currently held. As in 1978, about 10 percent of all agents contacted by phone declined to interview Mrs. Simmons on the basis of the coverage she currently possessed. The remainder, or 90 percent, of those called arranged to interview Mrs. Simmons. When insurance agents arrived, Mrs. Simmons presented her policy and mentioned she was currently covered by Medicare parts A and B. She would then ask for advice. Two committee staff members were present in the room with Mrs. Simmons. One took part in the interview and the other would take notes. In several instances a third subcommittee staff member took photos of the session.

The results of the interviews were shocking Even with the notoriety surrounding the previous investigation and legislative reform which followed, agent after agent engaged in sales tactics that would confuse the most knowledgeable insurance consumer. Again, adults—subcommittee staff—were always sitting in the room with Mrs. Simmons while the insurance interviews took place. The sales techniques used ranged from soft sell to high pressure sales tactics. (Incidentally, a 1978 committee staffer present in many of the 1978 interviews with insurance agents was again present during the 1986 interviews.) The bottom line is that nothing had changed in terms of sales tactics used during presentations observed by the subcommittee since the committee first publicized its findings documenting abusive marketing and sales practices in the purchase of Medicare supplemental insurance in 1978. Little impact was felt with agents marketing Medigap. If anything, sophistication in the presentation of the insurance policy highlighted the techniques currently employed and absent in 1978. Technology has reached the Medigap insurance line. Where graphics and tables were once used by agents to depict inadequacies in Medicare's coverage, video cassettes were standard sales equipment used in presentations witnessed by the subcommittee.

It is an understatement for the subcommittee to report Mrs. Simmons received a host of conflicting advice during and after the review of her policy by insurance agents.

Mrs. Simmons was in possession of adequate Medigap insurance, given her financial constraints. Nevertheless, literally every agent interviewed attempted to twist her out of her existing policy. Twisting is a practice whereby the agent encourages the client to cancel

perfectly good existing policies to sell a new policy which results in additional commission fees and imposes a new waiting period for preexisting conditions—which would leave her without health insurance protection for that condition for a specified period of time. Most of the agents tried to overload her with additional insurance which essentially duplicated coverage she currently held for a cost that in one instance exceeded her annual premium by about 400 percent. One simply dismissed her current insurance as noninsurance, as worthless certificates. One suggested that life insurance was a better avenue to explore in coping with health security. Some agents resorted to scare tactics and horror stories to erase any doubts Mrs. Simmons might have about purchasing their policies. One agent said, "I just sold this policy to an elderly couple and they would have lost their trailer without it You don't want that to happen to you, do you?" The double talk Mrs. Simmons witnessed would leave the average uninformed insurance consumer's head spinning. At the beginning of one interview, the agent apologized to Mrs. Simmons for this lack of knowledge regarding his company's Medicare supplemental insurance plan. He said, "We seldom get calls for this kind of insurance, so pardon me if I take a little time in explaining its benefit package." Toward the close of his presentation, he once again apologized to Mrs. Simmons for not bringing along an extra copy of a brochure describing his Medicare policy, adding, "I must have just run out of this brochure. It is such a popular policy. In fact, I'll probably get two more calls for it today." In the District of Columbia, two different agents representing the same insurance company presented their identical policies to Mrs. Simmons. The one agent told Mrs. Simmons to keep her policy and in addition to purchase his. In the former instance, she would have been overloaded because she would be paying for two policies where only one would pay if she needed to use them. In the latter instance, she would be asked to pay a higher annual premium on a policy which duplicated her existing insurance and also would leave her uninsured for a period of time due to her preexisting health condition.

Mrs. Margaret Dickson, a committee senior citizen investigator in 1978, participated in 1 of this 12 interviews conducted in 1986. Mrs. Dickson was interested to see whether she too would encounter a recommendation to buy more insurance, even though she was still overinsured. She was not disappointed in the end. A recommendation was made and will be detailed later in the report.

In all, a dozen interviews were held with insurance agents, some of whom represented more than one company. The visits took place in the metropolitan area: the District of Columbia, Virginia, and Maryland. Of the agents who appeared only one was scrupulously honest and did not attempt to force Mrs. Simmons to drop existing coverage in favor of his own, or to add his policy to the list she already carried. The subcommittee staff and its senior citizen investigator encountered 11 agents who engaged in questionable tactics.

The following is a description of the interviews that took place between subcommittee staff and senior citizen investigator and insurance agents in May and June 1986.

(1) In Virginia, an agent told Mrs. Simmons that she should drop her coverage with AARP because it wouldn't cover the high costs

that Medicare wouldn't pay. He then proceeded to explain the benefits of his policy without comparing it to Mrs. Simmons' current coverage under AARP. [As independent experts pointed out to the subcommittee, they provide essentially the same benefit package. However, Mrs. Simmon's AARP policy carriers a lower annual premium and also provides for a discount on out-of-hospital prescription drugs.] The agent then proceeded to misstate the services provided under his policy. He stated it would cover all nursing home care costs, skilled and custodial. In fact, it covers the Medicare gaps for skilled care up to 100 days and provides no coverage for custodial care. He stated that his policy would cover everything Medicare doesn't pay. It does not. He stated that his policy had a 60-day waiting period before the benefits become payable. In fact, his policy had a 6-month waiting period. In closing his presentation, the agent told Mrs. Simmons a story about his friend in Florida who incurred over $15,000 in hospital bills in one month alone and wound up with $30,000 in bills unpaid by Medicare or his private insurance. His policy, he said, would have prevented his friend's financial ruin.

(2) Another agent in Virginia seemed more interested in obtaining the right to manage Mrs. Simmons' financial affairs as a way of providing her with health security. He also encouraged her to consider annuities, and home and life insurance, which he also handled. Once rebuffed in his primary goal, he told her to drop her insurance for his, which he said was top of the line, adding that it cost $400 more a year than her AARP policy but that it was worth it because you pay for what you get. In fact, insurance experts told subcommittee staff that his policy would, for Mrs. Simmons, constitute essentially duplicate coverage. It was actually more interesting listening to what the agent did not tell Mrs. Simmons about the plan than what he did discuss with her. When asked directly if his plan didn't cover care in a nursing home for Alzheimer's, he simply did not reply. He didn't tell her that she would lose coverage for prescription drugs, for coverage while traveling overseas, or for her preexisting condition, by switching to his company's policy.

(3) An agent in the District of Columbia said that Medicare part A was the strongest part of the Medicare program and that coupling it with a good Medigap policy would make it possible for one to sleep at night knowing expenses would be covered. His policy, he added, would provide that needed sleep. He told Mrs. Simmons that the weakest area of protection under the Medicare Program was nursing home coverage. Here again, the agent stated that his policy has relieved the fears that thousands of his clients who are seniors have about potential nursing home expenses. When specifically asked whether his insurance plan would cover care in a nursing home for an Alzheimer's patients, he skirted the issue, responding by noting that his plan did cover nursing home care that Medicare didn't pay—implying that his plan would cover custodial, not just skilled care in a nursing home. When pressed again, he responded by defining the difference between skilled and custodial care, saying that skilled care is required for serious illnesses and we cover that. He added, custodial care is just care in feeding, bathing and such—nothing serious. He never mentioned whether his plan would cover custodial care. He pointed out to Mrs. Simmons

that AARP could cancel her any time and his policy was guaranteed renewable—paying literally all the costs that Medicare did not cover. As this report suggests, no policy can fulfill that promise. This agent peppered his entire presentation with horror stories, including one about his client who recently had a serious illness, and Medicare coverage ran out. His policy paid the $25,000 Medicare wouldn't pay. He also told her that he just sold this policy to an elderly couple and they would have lost their trailer without it. You don't want that to happen to you, do you? His final recommendation: that she drop her AARP policy and take his, which in the State of Wisconsin has a loss ratio of 17 percent, substantially less than the 60 percent loss ratio on policies on the coverage nationwide. His policy would cost her about $300 more a year than her AARP policy and would leave her uninsured for a period of 2 months.

(4) Another D.C. agent told Mrs. Simmons that he seldom sells his company's Medicare supplemental insurance policy and apologized for his lack of knowledge regarding the plan's coverage. He then proceeded to show a cassette tape explaining the company's coverage for Medicare beneficiaries. Toward the end of the presentation, he apologized for not having a brochure to leave with Mrs. Simmons. He said, "I must have just run out of this brochure. It is such a popular policy. In fact, I'll probably get two more calls for it today," Such double talk punctuated his presentation and completely confused Mrs. Simmons, who was getting fairly informed regarding various insurance plans available. He was selling a policy identical to a policy presented earlier in the day to Mrs. Simmons by a different agent. In this instance, however, the agent recommended that she buy his and keep her AARP policy, while the other agent suggested that she buy his policy but drop hers. If Mrs. Simmons had purchased this agent's policy and retained her own, she would have been overloaded and the agent would have committed a criminal offense.

(5) Another agent in the District of Columbia reviewed Mrs. Simmons' AARP plan and said he felt it was a good one and that it covered drugs. However, he felt that his two policies coupled with Medicare and its coverage would make for better protection. One of his plans essentially duplicated Mrs. Simmons' AARP coverage, minus the drug coverage. Another policy he recommended that she buy was his nursing home policy which he felt was a more important benefit than her drug coverage. His policy would cover both skilled and nursing home care, he said. The agent told Mrs. Simmons although the two policies would cost about $1,500 more a year than she was currently paying for her AARP policy, it would be well worth it because the cost of health care in D.C. is far greater than the cost of health care in Nevada. He stated that his policies would cover the higher costs, while AARP would not. One of his policies was identical to her AARP policy and did not provide coverage for out-of-hospital prescription drugs. The other does not guarantee that the policy will be in force in 10 or 15 years for all who purchased it in a particular State. So, essentially, she could pay up to $11,000 in 10 years and have the policy cancelled before she used it. He didn't mention this. He said it was guaranteed renewable. He failed to mention unless this particular policy is can-

celled for all policyholders in the States who purchased it, which could happen.

(6) One agent in Washington, DC, quickly went to work disparaging the AARP Medigap policy Mrs. Simmons held. "AARP only covers what Medicare covers," she told her. "I've got two others that offer much more than your policy, for about the same price." The first plan she pronounced a better plan than AARP, definitely, although later examination by subcommittee staff revealed the benefits to be remarkably similar. Her company's plan would pay the policyholder's Part A deductible and pay 20 percent of all doctor bills which Medicare does not cover, both services AARP's Medigap policy does provide. The agent seemed most excited about her company's second plan, a supplement to a supplement, which she assured Mrs. Simmons was not double coverage. The policy, which again performed many of the functions already available under the standard AARP Medigap plan, was portrayed as a real bargain. If purchased as a supplement to any standard Medigap plan, it would cost only $6.85 a month. Pressed repeatedly about long-term custodial care coverage under either of her company's plans, the agent made an interesting statement. She praised the excellent hospital coverage available under her company's two plans and told Mrs. Simmons, "Most doctors will help you out if you find yourself with that kind of long-term illness. Even though you might not feel very good, the doctor can send you home from the hospital for a short time. Then, you can be readmitted to the hospital a few days later. This can happen again and again until you've used up all your part A Medicare days." In the event that we did not like that approach, the agent also described a nursing home plan which would cost $138 a year for a person aged 65–69. The policy would pay nursing home expenses for 1 year ($50/day for the first 90 days, $25/day for days 91–365.) The agent failed to mention that this policy does not cover custodial care and that it does have a stringent preexisting condition limitation. As her final selling point, the agent reminded Mrs. Simmons of her company's proximity to Mrs. Simmons' home, the interview site. "Doing insurance business by mail is a drag. We're right down the street so you can get all the attention you need."

(7) Another salesman in Washington, DC, was reasonably well versed in Medicare and the limits of its coverage. He converted this knowledge into a scare tactic, however, by telling Mrs. Simmons how the Medicare part A deductible had shot up from $400 and $492 in one year. "We don't have any control over this kind of thing. It's likely just to keep on climbing." After reviewing Mrs. Simmons' AARP policy, he dismissed it as mail order policy, basically. He said that it would help to own my policy, too. He told how his company would pay the full deductible under parts A and B of Medicare, and all copayments for hospital stays lasting more than 60 days. Even at the point at which Medicare ceases payment for a hospital stay, after day 150, he said, "We'll pay 100 percent of all customary hospital charges." This sounds most generous but, as the subcommittee's research reveals, only a minuscule proportion of elderly persons is hospitalized long term. The salesman described his company's nursing home policy, which would pay for long-term stays in a skilled nursing facility and which costs $586 a year.

"This is the best policy we've seen of this type," he said, although the terms seem similar to many other policies of this type reviewed by the subcommittee. He did not have a copy of this plan with him but said, "You can keep it as long as you live." He also hinted that going on Medicaid might be the best course if one is stricken with a catastrophic illness. He said that many elderly give their assets away, to children or someone in the family. "It's a difficult situation, but at least that way you're eligible for Medicaid." But this statement, seemingly contradictory to what he had said before, did not prevent him from going for the big finish. "Insurance buys you peace of mind," he said. "Even if you're feeling fine today, you may not tomorrow." He also pointed out the ease with which payment could be made—annually, semiannually, quarterly, or monthly, and with any major credit card.

(8) This Maryland salesman, one of the fastest talking and one whose presentation was among the fuzziest of the 12 agents, read through Mrs. Simmons' policy and said, "Hmmm. This isn't as good as I first thought." He said the language in the policy was confusing and pointed especially to the fact that AARP covered "eligible expenses for days 1-90 under Medicare." "How can you make sense of that? You go to their glossary and there's another definition. A definition defined by a definition defined by a definition." He described his company as "one of the best," but said it did most of its business in the Midwest so we probably hadn't heard of it. He said this plan's special strengths were its excellent hospitalization benefits and the fact that it covered most major medical expenses, which turned out to be a questionable statement. The agent made a strong case for the need for Medigap coverage. He related the sad story of a woman who had a long hospital stay and spent all the family's savings on health bills. The husband was left impoverished. "I know you don't want to find yourself in a situation like that," he told Mrs. Simmons. Asked about long-term care coverage under this company's plan, the saleman said his company's plan A would pay $61.50 a day for the first 30 days of care in a post-hospital skilled nursing facility. This seemed far from the long-term care Mrs. Simmons had in mind. The company's more upscale plan B would pay $92.25 a day for 100 days of skilled care. The premium is $64.58 a month. The agent advised Mrs. Simmons, who remarked on the high price, that her monthly premium was of no consequence, really. "You buy an insurance policy to collect on it, not to pay the premium." Mrs. Simmons asked whether out-of-hospital prescription drugs were covered. He said neither of his policies included this feature but that, with her membership in AARP, Mrs. Simmons was all taken care of in that department. She could go to that group's K Street pharmacy in Washington, DC and receive a pretty good price on drugs anyway.

(9) This saleman, who met with subcommittee staff in Maryland, was the most knowledgeable about Medicare. He was also the one agent to state frankly that Mrs. Simmons' coverage was adequate for one with her budget and that his company's policy could not do better. He levelled with her about long-term custodial care, which he called a time bomb waiting to go off in this country, but said that virtually no policies in this country cover this much-needed type of care. He was knowledgeable about the increasing out-of-

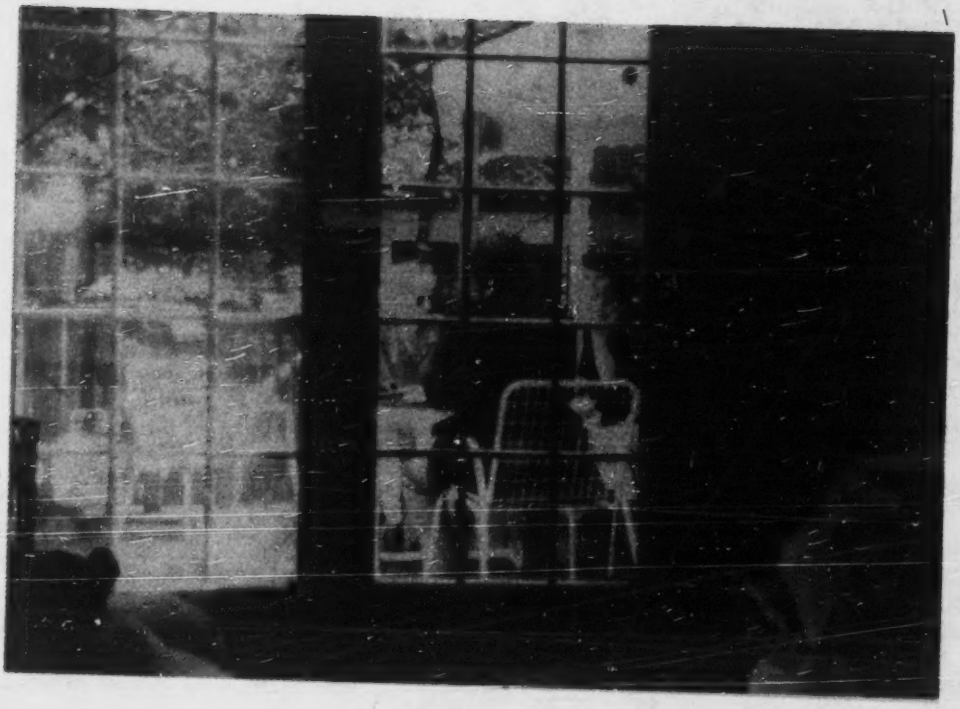
pocket contributions of the elderly for their health care and even alluded to a Washington Post article he'd read that morning on that topic. But, upon leaving, he said, "You're doing OK with what you've got. It's not perfect, but it's about the best that's out there."

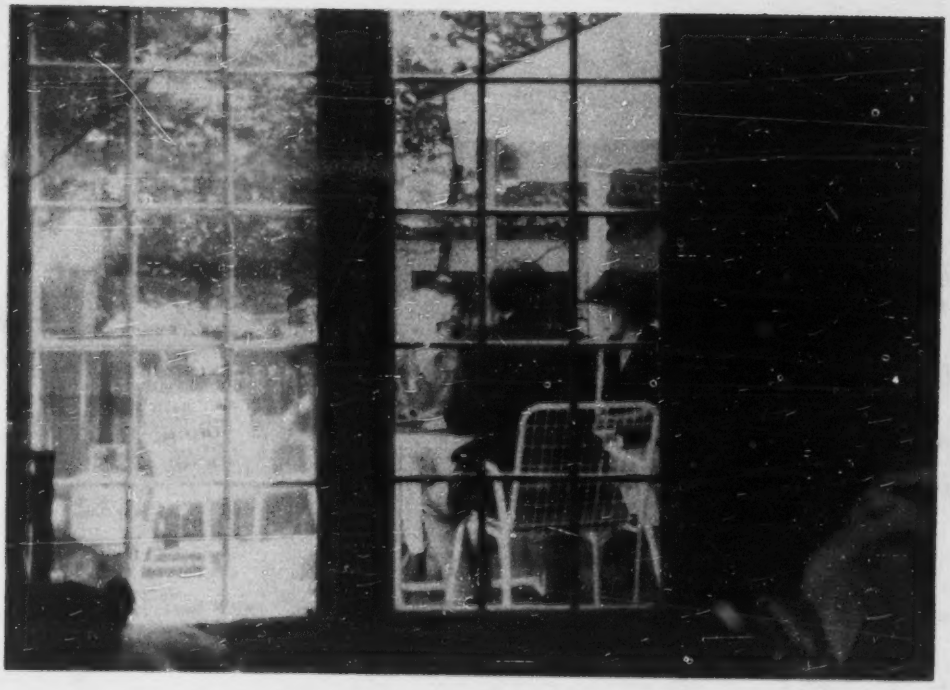
(10) and (11) This interview with D.C. agent 10 became both 10 and 11. Agent 10 brought Agent 11 with him. Both were a team working for the same company. It should be noted that the same company in Virginia told the subcommittee that it was against company policy for them to sell on top of another policy or switch policies. Apparently, this company did not have a similar policy in place in the District of Columbia. The agents were advised that Mrs. Simmons already had Medicare and the AARP plan. Without reviewing her AARP plan (and there are four of them), one stated, "With our plan she'll be covered for everything that Medicare doesn't cover." The other agent then proceeded to explain to Mrs. Simmons that his parents had coverage under Medicare parts A and B, Blue Cross and Blue Shield, and one AARP Medigap policy. He said he personally reviewed their coverage and decided they would have better coverage with his supplemental policy. The agent said he had his parents drop their original coverage and just carry his company's policy. Both agents then briefly discussed what coverage Medicare provided and what expenses their Medigap policy would pick up. One agent advised that his company's policy would cost Mrs. Simmons $42.38 per quarter in comparison to her current $38 a month premium, and he reiterated that "Mrs. Simmons won't need anything else." Mrs. Simmons asked the agents if she would be covered if she got Alzheimer's disease. They advised her that her hospital bills, skilled nursing care at home, and expenses relating to skilled nursing home care would all be covered. They further added that their policy would also provide hospice care benefits. It should be noted that neither agent mentioned that patients suffering from Alzheimer's disease rarely demand skilled nursing home care. Nor did they mention custodial nursing home care or the fact that their policy did not cover such care. Mrs. Simmons expressed fear of not being covered immediately because she had been treated for hypertension and was currently taking medication to control it. The agents advised there would be no preexisting condition clause or waiting period. The agents advised they would leave a blank application, but one of them would have to witness Mrs. Simmons' signature on the application, which they did. Neither agent ever reviewed Mrs. Simmons' Medigap policy or made a written or even an oral comparision of their policy and hers.

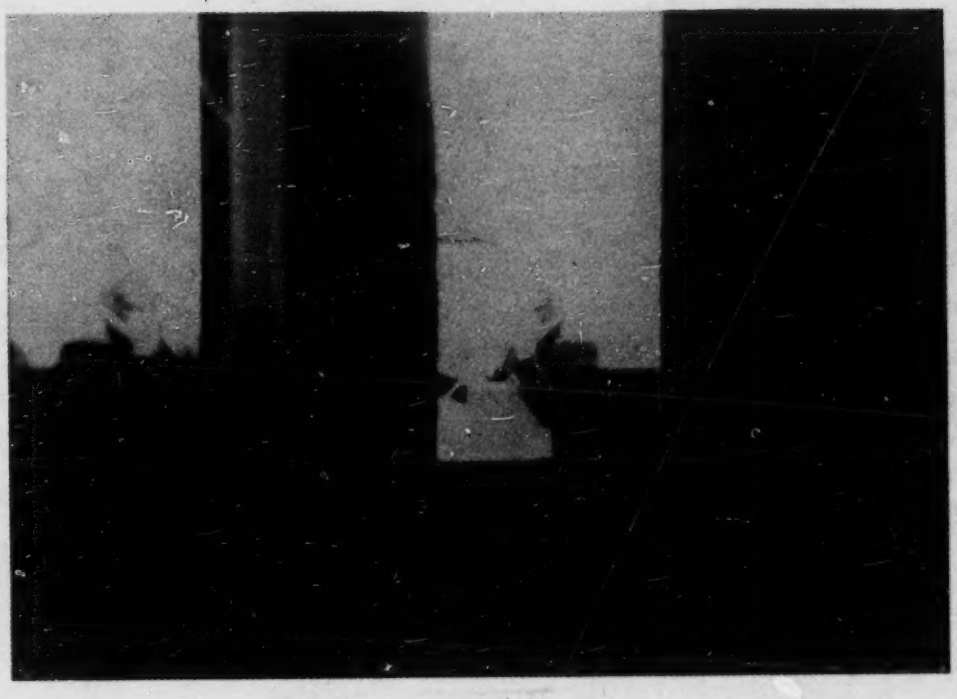
(12) In the District of Columbia, an agent interviewed Mrs. Margaret Dickson, a subcommittee senior citizen investigator in 1978. She was overinsured with four policies. The agent had a soft sell approach. He never reviewed any of her policies, except to suggest that one lacked complete information and he would need that to make a final recommendation. He told Mrs. Dickson that it appeared she had decent coverage and she personally had to determine whether more would be better. He added, "It (insurance) doesn't cost much when it comes time to use it." He left without suggesting she review any of his policies and telling her he didn't know of any good nursing home policies which would cover custodi-

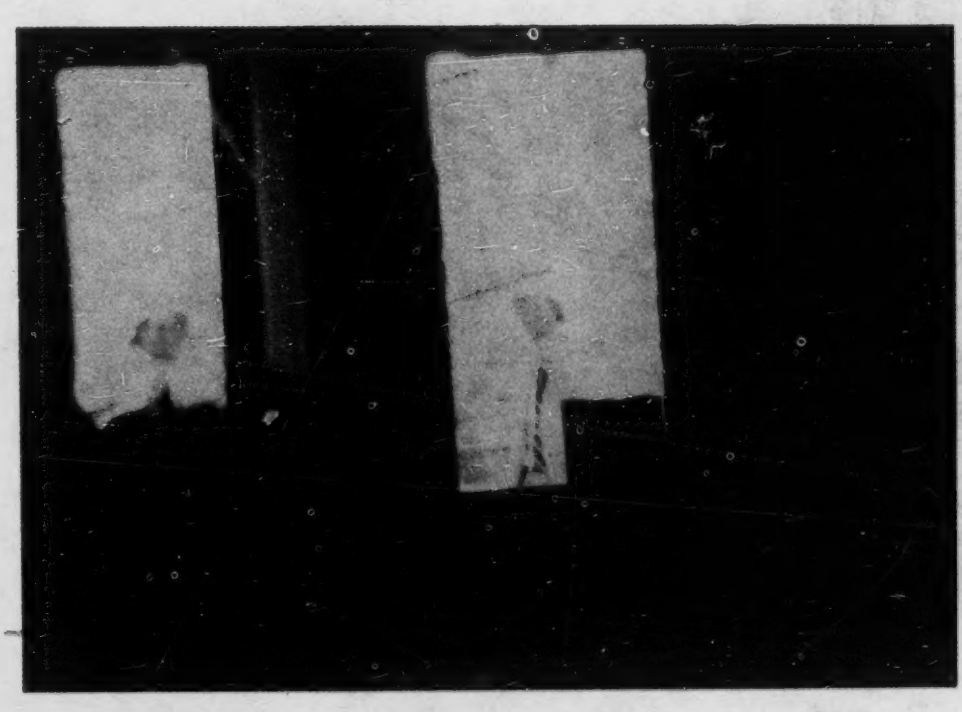
al care in the D.C. area. We initially rated him as giving an honest evaluation of her situation, although we wondered why he didn't ask to review her other policies. However, several days later, we rerated him. A letter with three insurance applications arrived. He recommended she sign on the dotted line with an X on all forms and remit a check for a total annual premium in excess of $900 a year for the three policies he thought would help her: a new service policy, a dread disease policy, and a hospice plan. He didn't advise her as to what to do with her existing coverage. He simply said he had called AARP and found out what he suspected—that her coverage was outdated.

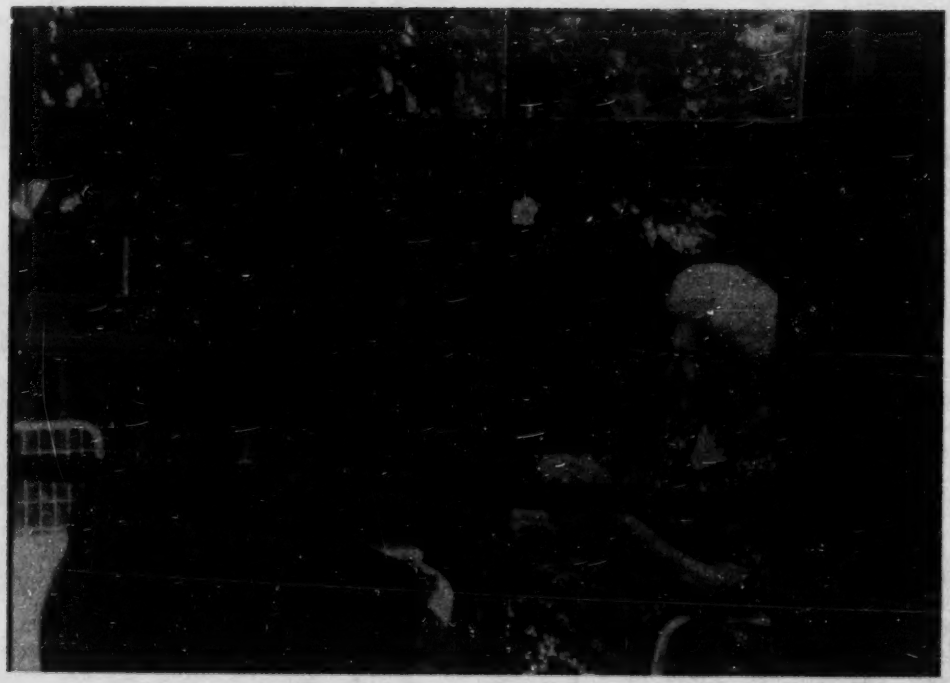
[Photographs of the subcommittee's May–June 1986 investigation follow:]











V. REGULATION OF MEDICARE SUPPLEMENTAL INSURANCE BY THE STATES: TWO SURVEYS OF 50 STATE INSURANCE DEPARTMENTS

It is obvious from the previous sections of this report that abuses in the sale of supplemental insurance to the elderly persist. Abuses are not confined to a specific region of the United States, but occur nationwide, and they have increased since the 1978 committee investigation. It is appropriate to ask at this point, "Who is responsibe for regulating the health insurance industry and what has been done about curbing the increasing incidence of abuse in the sale of such insurance to the elderly?" In part, the answer is that the States still retain near-exclusive authority to regulate the insurance industry.

As background, it is important to note that the Federal Government largely abrogated its responsibility for regulating insurance when the Congress enacted the McCarran-Fergusson Act in 1945. In technical terms, the law says that no act of Congress, unless specifically relating to the business of insurance, shall be construed to invalidate, impair, or supercede any State laws regulating the business of insurance. However, the Congress did not close the door to Federal regulation completely. It reserved the right to regulate through antitrust laws and the Federal Trade Commission to the extent that such business is not regulated by State insurance departments. The role of the Federal Government relative to the regulation of insurance will be discussed in section VI of this report.

If the primary responsibility for regulating the sale of insurance rests with the States, the logical question to ask at this point is, "How effective have the States been in their regulation of health insurance and more specifically of Medicare supplemental policies?" As of 1978, many States, such as Wisconsin, Kansas, and California, were doing an excellent job. These States had conducted investigations, resolved consumer complaints, and promulgated new and effective regulations to deal with many of the complicated and perplexing problems in the health insurance field. Many States followed their lead and, as of 1986, only four States—New York, Connecticut, Massachusetts, and Wyoming—had not implemented the National Association of Insurance Commissioners (NAIC) model regulations that Congress recommended that each State adopt. The regulations were adopted in many forms: through guidelines, laws and rankings for insurance companies selling in the State, and abuse complaints. Regulatory reform proposals in 1978 were compared with identical survey data obtained from the States in the 1984 Subcommittee questionnaire. A profile of the average insurance department emerged from the data. On average, the State insurance departments reported steady increases in their operating costs and in total dollar volume of all premiums paid for all kinds of insurance sold within an individual State. At the same time, State insurance commissioners reported a steady decline in departmental staff assigned to monitor and resolve complaints. States are reviewing approximately 7,500 policies a year today, compared to about 5,800 in 1977. Of the over 7,500 policies reviewd, States will each approve about 7,000 for sale in their respective boundaries.

Although the average number of licensed health insurance agents in each State has increased from about 2,750 in 1977 to about 24,500 in 1983, the requirements for licensing insurance agents have not been toughened. Furthermore, the number of agents who have had their licenses revoked has only increased from an average of 15 per State in 1977 to 22 per State in 1983. In 1983, only about 7 insurance companies in each State were fined or disciplined.

Since the 1977 survey, a majority of the States have issued regulations covering the various aspects of health insurance policies in general (and Medicare supplemental policies in particular) as taken from the NAIC model bill. Most of the States (92 percent reported regulations relating to the use of preexisting condition clauses in Medicare supplemental policies. They also have regulations relating to permissible, rather than deceptive, advertising of health and accident policies. However, only seven States have mandatory review procedures for advertisements relating to insurance policies sold by mail.

Although the number of States which have minimum loss ratios mandated by law has increased substantially since 1977, they numbered only 34 in 1984. The average loss ratios for Medicare supplemental policies was 60 percent.

In 1977, only seven States mandated that agents provide a State-approved consumer guide at the time of sale. By 1984, the number had increased to 36.

The variety of abuses reported by the States remained basically unchanged from 1977 to 1983. That is, the same problems and/or abuses are still prevalent. The Baucus/Pepper legislation, among other things, made overloading a criminal offense. Nevertheless, the prevalence of such abusive activity as reported by the States has not declined, but rather, it has increased. In fact, 44 States reported receiving complaints of overloading, as compared to 38 States in 1977.

What follows is a more detailed analysis of the State insurance departments' experiences with Medicare supplemental insurance.

ANALYSIS OF THE STATES EXPERIENCES WITH REGULATING MEDICARE SUPPLEMENTAL INSURANCE: 1977–1986

The first section of the 1984 questionnaire asked the State commissioners how much money they had in their budgets, how many employees were working for the Department, the total dollar volume of all premiums paid for all kinds of insurance sold in their respective States in 1983, and the annual salary for the State insurance commissioner. By compiling the replies received from the States, a profile of the average State insurance department has been created.

In order to regulate the business of insurance, the average State insurance department in 1983 had a budget of more than $4.3 million (see table 1), which would pay for an average of 118 employees (see table II). The commissioners were paid an average salary of $46,464 (see table III). These figures are comparatively higher than in 1977, when the average department had a budget of $3.2 million which paid for an average of 141 employees. The insurance com-

missioner drew a mean salary of $35,000 per year. In 1983, the average department had one employee for every $44 million in premiums for insurance that it had to regulate, as compared to one employee for $23 million in premiums in 1977 (see table IV). In 1983, the typical department had an investigative staff of 10 people, only 7 of whom were assigned to investigate abuses in the sale of accident/health insurance. This is compared to 1977, where the average department had a staff of 15 people, 9 of whom were assigned to accident/health insurance (see table V). In 1977, Florida had the largest investigative staff at 71. Hawaii and South Dakota had the fewest—each had only one investigator (see table V). In 1977, only 18 States had a certified actuary on their staff, and only 24 States did in 1983 (see table VI).

TABLE I.—WHAT IS THE BUDGET FOR YOUR OFFICE THIS YEAR? WHAT WAS IT IN 1983? IN 1977?

	1984	1983	1977
Alabama	2,083,207	2,006,931	NA
Alaska	960,000	960,000	NA
Arizona	1,599,000	1,496,900	1,116,000
Arkansas	1,725,920	1,784,442	981,175
California	16,962,000	15,544,000	7,331,475
Colorado	1,759,467	1,741,488	1,294,844
Connecticut	2,039,000	1,855,051	1,256,837
Delaware	1,363,000	1,172,000	NA
District of Columbia	759,500	770,200	667,300
Florida	22,948,483	23,281,164	9,779,406
Georgia	NA	NA	NA
Hawaii	769,575	743,683	269,506
Idaho	NA	NA	522,000
Illinois	7,879,000	7,232,390	NA
Indiana	1,172,025	1,119,463	1,686,636
Iowa	2,651,364	2,726,184	1,536,000
Kansas	3,600,954	3,275,384	2,159,127
Kentucky	3,854,400	3,533,000	1,557,200
Louisiana	2,097,524	1,942,217	1,194,230
Maine	1,975,000	716,000	NA
Maryland	NA	3,144,779	2,394,453
Massachusetts	3,500,000	NA	3,672,000
Michigan	5,449,700	5,190,900	4,286,400
Minnesota	NA	NA	NA
Mississippi	1,247,861	1,161,276	NA
Missouri	1,464,741	1,494,006	1,358,091
Montana	649,728	613,048	NA
Nebraska	1,857,777	1,129,992	NA
Nevada	2,067,791	1,844,138	868,511
New Hampshire	1,396,233	1,165,816	782,618
New Jersey	6,174,792	6,135,418	3,958,967
New Mexico	940,000	868,000	518,000
New York	31,146,500	29,459,345	19,014,000
North Carolina	7,099,966	6,654,874	3,500,000
North Dakota	1,207,850	962,947	NA
Ohio	4,700,000	3,700,000	2,357,416
Oklahoma	NA	NA	NA
Oregon	2,200,000	2,300,000	NA
Pennsylvania	7,210,000	7,414,000	5,400,000
Rhode Island	NA	NA	NA
South Carolina	3,882,755	3,954,106	3,139,163
South Dakota	482,773	356,069	245,275
Tennessee	2,397,000	2,153,600	7,627,500
Texas	23,891,879	18,455,763	13,239,372
Utah	1,700,000	1,530,000	976,000

TABLE I.—WHAT IS THE BUDGET FOR YOUR OFFICE THIS YEAR? WHAT WAS IT IN 1983? IN 1977?—Continued

	1984	1983	1977
Vermont	579,178	534,746	NA
Virginia	4,457,065	4,240,268	2,200,000
Washington	3,049,193	2,601,563	NA
West Virginia	1,049,812	1,085,901	398,477
Wisconsin	2,953,200	2,550,700	1,900,000
Wyoming	871,658	874,695	NA
American Samoa	NA	NA	NA
Guam	NA	NA	NA
Puerto Rico	1,163,000	1,123,000	NA
Virgin Islands	NA	NA	NA
Total	200,989,871	184,559,477	
Average per State	4,369,345	4,013,031	3,211,411

TABLE II(a).—WHAT IS THE TOTAL NUMBER OF FULL-TIME EQUIVALENTS EMPLOYED BY YOUR OFFICE? HOW MANY CLERICAL? HOW MANY PROFESSIONALS? (1983)

	Total number employed	Clerical	Professional
Alabama	59	20	39
Alaska	19	04	15
Arizona	59	28	31
Arkansas	63	41	22
California	410	59	351
Colorado	60	18	32
Connecticut	71	22	40
Delaware	25	11	14
District of Columbia	22	7	15
Florida	542.5	211.5	331
Georgia	103	46	57
Hawaii	23	7	16
Idaho	NA	NA	NA
Illinois	233	55	178
Indiana	82	32	50
Iowa	93	28	65
Kansas	120.5	51.3	70.2
Kentucky	67	32	35
Louisiana	70	45	25
Maine	23	8	15
Maryland	129	40	89
Massachusetts	130	50	80
Michigan	129	45	84
Minnesota			
Mississippi	54	24	30
Missouri	68.5	30	38.5
Montana	22	7	15
Nebraska	50	16	34
Nevada	54	16	38
New Hampshire	31	8	23
New Jersey	250	72	178
New Mexico	32	15	8
New York	689	248	441
North Carolina	201	46	155
North Dakota	22	8	14
Ohio	110	44	66
Oklahoma	57	NA	NA
Oregon	53	17	36
Pennsylvania	200	61	139
Rhode Island	NA	NA	NA

TABLE II(a).—WHAT IS THE TOTAL NUMBER OF FULL-TIME EQUIVALENTS EMPLOYED BY YOUR OFFICE? HOW MANY CLERICAL? HOW MANY PROFESSIONALS? (1983)—Continued

	Total number employed	Clerical	Professional
South Carolina	100	25	75
South Dakota	15	8	7
Tennessee	79	39	40
Texas	689	432	257
Utah	45	15	30
Vermont	18	6	12
Virginia	106	24	82
Washington	73	32	41
West Virginia	37	14	23
Wisconsin	85	22	63
Wyoming	23	11	14
American Samoa	NA	NA	NA
Guam	NA	NA	NA
Puerto Rico	80	29	51
Virginia Islands	NA	NA	NA
Average	118	43.5	73

TABLE II(b).—WHAT IS THE TOTAL NUMBER OF FULL-TIME PEOPLE EMPLOYED BY YOUR OFFICE? HOW MANY PROFESSIONALS? (1977)

	Employees	
	Full-time	Professional
Alabama	40	
Alaska	17	
Arizona	60	21
Arkansas	52	35
California	384	232
Colorado	65	46
Connecticut	71	50
Delaware	24	
District of Columbia	24	17
Florida	473	267
Georgia		
Hawaii	14	8
Idaho	22	11
Illinois		
Indiana	77	41
Iowa		
Kansas	133	73
Kentucky	55	25
Louisiana	58	22
Maine		
Maryland	132	83
Massachusetts	227	164
Michigan	162	100
Minnesota		
Mississippi		
Missouri	128	85
Montana		
Nebraska		
Nevada	33	19
New Hampshire	35	
New Jersey	234	134
New Mexico	27	7
New York	694	427

TABLE II(b).—WHAT IS THE TOTAL NUMBER OF FULL-TIME PEOPLE EMPLOYED BY YOUR OFFICE? HOW MANY PROFESSIONALS? (1977)—Continued

	Employees	
	Full-time	Professional
North Carolina	204	150
North Dakota		
Ohio	97	61
Oklahoma		
Oregon	58	33
Pennsylvania	219	164
Rhode Island		
South Carolina	104	68
South Dakota	14	8
Tennessee	469	159
Texas	604	335
Utah	31	12
Vermont		
Virginia	84	57
Washington		
West Virginia	26	13
Wisconsin	78	58
Wyoming		
American Samoa		
Guam		
Puerto Rico		
Virgin Islands		
Average per State	141	90

TABLE III.—WHAT IS THE SALARY FOR THE STATE INSURANCE COMMISSIONER PER YEAR?

	1984	1977
Alabama	48,037	NA
Alaska	NA	NA
Arizona	48,900	27,000
Arkansas	41,272	25,327
California	55,000	40,764
Colorado	37,692	35,892
Connecticut	52,401	30,215
Delaware	NA	NA
District of Columbia	51,058/64,674	47,500
Florida	59,385	42,000
Georgia	NA	NA
Hawaii	36,300	42,500
Idaho	NA	27,540
Illinois	43,000	NA
Indiana	47,814	38,000
Iowa	35,000	NA
Kansas	42,610	25,000
Kentucky	50,000	35,000
Louisiana	60,169	35,000
Maine	33,004/49,025	NA
Maryland	51,200	42,000
Massachusetts	NA	27,000
Michigan	49,000	33,675
Minnesota	NA	NA
Mississippi	45,000	NA
Missouri	34,000	33,252
Montana	31,692	NA
Nebraska	37,781	NA

TABLE III.—WHAT IS THE SALARY FOR THE STATE INSURANCE COMMISSIONER PER YEAR?—Continued

	1984	1977
Nevada	36,982	27,518
New Hampshire	50,534	NA
New Jersey	70,000	49,000
Mew Mexico	NA	NA
New York	65,700	47,800
North Carolina	50,328	35,758
North Dakota	43,380	NA
Ohio	49,300	32,000
Oklahoma	40,000	NA
Oregon	47,904	NA
Pennsylvania	58,000	35,000
Rhode Island	NA	NA
South Carolina	56,221	41,338
South Dakota	NA	22,749
Tennessee	46,500	46,524
Texas	59,700	38,100
Utah	NA	26,000
Vermont	37,800	38,800
Virginia	50,672	NA
Washington	37,200	NA
West Virginia	31,500	28,000
Wisconsin	45,000	34,200
Wyoming	NA	NA
American Samoa		
Guam		
Puerto Rico	38,000	
Virgin Islands		
Average	46,464	35,181

TABLE IV.—WHAT IS THE TOTAL DOLLAR VOLUME OF ALL PREMIUMS PAID FOR ALL KINDS OF INSURANCE IN YOUR STATE FOR 1983 OR MOST RECENT YEAR? FOR 1977?

	1983	1977
Alabama	3,201,137,879	NA
Alaska	NA	NA
Arizona	2,499,823,500	1,459,000,000
Arkansas	34,736,074.69	941,000,000
California	25,300,000,000	17,246,000,000
Colorado	NA	1,528,000,000
Connecticut	4,077,000,000	2,317,000,000
Delaware	NA	500,000,000
District of Columbia	363,029,000	536,000,000
Florida	9,485,127,475	824,000,000
Georgia	NA	NA
Hawaii	796,785,567	421,000,000
Idaho	24,107,400	485,000,000
Illinois	12,758,123,833	NA
Indiana	5,850,000,000	1,288,000,000
Iowa	3,140,000,000	NA
Kansas	2,134,880,175.50	NA
Kentucky	2,827,313,000	1,724,000,000
Louisiana	4,453,000,000	2,280,000,000
Maine	787,551,744	NA
Maryland	68,644,859	2,470,000,000
Massachusetts	NA	4,000,000,000
Michigan	10,727,858,000	6,570,000,000
Minnesota	NA	NA

TABLE IV.—WHAT IS THE TOTAL DOLLAR VOLUME OF ALL PREMIUMS PAID FOR ALL KINDS OF INSURANCE IN YOUR STATE FOR 1983 OR MOST RECENT YEAR? FOR 1977?—Continued

	1983	1977
Mississippi	NA	NA
Missouri	5,203,545,905	3,817,000,000
Montana	NA	NA
Nebraska	1,730,227,008	NA
Nevada		NA
New Hampsire	748,000,000	NA
New Jersey	6,869,070,000	14,150,000,000
New Mexico	NA	15,000,000
New York	23,515,722,000	11,759,000,000
North Carolina	4,584,632,988	61,000,000
North Dakota	613,154,696	NA
Ohio	10,425,004,651	7,200,000,000
Oklahoma	NA	NA
Oregon	2,900,000,000	NA
Pennsylvania	13,202,689	8,000,000,000
Rhode Island	NA	NA
South Carolina	2,400,000,000	1,344,000,000
South Dakota	27,150,155	472,000,000
Tennessee	3,492,116,000	2,264,000,000
Texas	14,631,573,481	8,708,000,000
Utah	NA	697,000,000
Vermont	220,000,000	NA
Virginia	5,644,982	2,239,000,000
Washington	4,000,000,000	NA
West Virginia	1,400,000,000	816,000,000
Wisconsin	5,305,313,899	2,943,000,000
Wyoming	NA	NA
American Samoa	NA	NA
Guam	NA	NA
Puerto Rico	796,018,971	NA
Virgin Islands	NA	NA
Total	196,237,119,262	109,434,000,000
Average	5,164,134,717	3,530,000,000

TABLE V(a).—OF THE ABOVE NUMBER, HOW MANY PROFESSIONALS MAKE UP YOUR INVESTIGATIVE STAFF? HOW MANY ARE ASSIGNED TO HEALTH INSURANCE COMPLAINTS?

	Investigative staff	Assigned to health insurance complaints
Alabama	3	2
Alaska		
Arizona	8	(1) 4
Arkansas	6	2
California	35	35
Colorado	3	(2)
Connecticut	8	8
Delaware	4	(2)
District of Columbia	7	1
Florida		
Georgia	29	12
Hawaii	3	1
Idaho		
Illinois	30	15
Indiana	1	2
Iowa	8	2
Kansas	10	6
Kentucky	5	3
Louisiana	8	3

TABLE V(a).—OF THE ABOVE NUMBER, HOW MANY PROFESSIONALS MAKE UP YOUR INVESTIGATIVE STAFF? HOW MANY ARE ASSIGNED TO HEALTH INSURANCE COMPLAINTS?—Continued

	Investigative staff	Assigned to health insurance complaints
Maine	2	(4)
Maryland	16	3
Massachusetts	50–60	15
Michigan	4	(5)
Minnesota		
Mississippi	7	3
Missouri	2	(5)
Montana	15	5
Nebraska	3.5	1.5
Nevada	32	7
New Hampshire	2	2
New Jersey	18	4
New Mexico	1	1
New York	14	(5)
North Carolina	24	(6)
North Dakota	4	2
Ohio	12	3
Oklahoma	2	(5)
Oregon	8	[7] 3
Pennsylvania	36	7
Rhode Island	0	0
South Carolina	4	2
South Dakota	1	(4)
Tennessee	14	(4)
Texas	93	88
Utah	5	3
Vermont	0	0
Virginia	7	[8] 4
Washington	2	(4)
West Virginia	5	[9] 2
Wisconsin	7.5	4.5
Wyoming	2	0
American Samoa		
Guam		
Puerto Rico	16	6
Virgin Islands		
Average	10	7

[1] Estimate.
[2] Not segregated.
[3] Not designated.
[4] None exclusively.
[5] None specifically.
[6] Varies.
[7] Plus 2 part time.
[8] Life and health.
[9] No full time.

TABLE V(b).—INVESTIGATORS EMPLOYED BY STATE INSURANCE DEPARTMENTS (1977)

	Professionals on the investigative staff	Professionals assigned to investigate health insurance complaints
Alabama	5	2.5
Alaska	9	9
Arizona	9	9
Arkansas	4	3
California	54	
Colorado	5	3
Connecticut	42	6
Delaware		

TABLE V(b).—INVESTIGATORS EMPLOYED BY STATE INSURANCE DEPARTMENTS (1977)—Continued

	Professionals on the investigative staff	Professionals assigned to investigate health insurance complaints
District of Columbia	0	0
Florida	71	71
Georgia	31	.....
Hawaii	1	1
Idaho	2	1
Illinois	15	.....
Indiana	1	1
Iowa	3	1.5
Kansas	10	6
Kentucky	6	2
Louisiana	6	3
Maine	.....	.....
Maryland	14	14
Massachusetts	14	14
Michigan	6	.....
Minnesota	6	6
Mississippi	15	8
Missouri	10	10
Montana	17	.....
Nebraska	.....	.....
Nevada	12	4
New Hampshire	5	.....
New Jersey	14	3
New Mexico	2	1
New York	55	64
North Carolina	59	6
North Dakota	13	.....
Ohio	12	4
Oklahoma	6	.....
Oregon	.....	.....
Pennsylvania	22	22
Rhode Island	.....	2
South Carolina	3	3
South Dakota	1	1
Tennessee	17	16
Texas	10	10
Utah	5	2
Vermont	.....	.....
Virginia	11	4
Washington	33	.....
West Virginia	3	1
Wisconsin	34	11
Wyoming	3	.....
American Samoa	.....	.....
Guam	.....	.....
Puerto Rico	.....	.....
Virgin Islands	.....	.....
Average	15	9

TABLE VI.—STATES WITH A CERTIFIED ACTUARY ON THEIR STAFF

	1984		1977	
	Yes	No	Yes	No
Alabama	X	.....	.....	.....
Alaska	.....	.....	.....	.....
Arizona	X	.....	.....	0
Arkansas	.....	0	X	.....

TABLE VI.—STATES WITH A CERTIFIED ACTUARY ON THEIR STAFF—Continued

	1984		1977	
	Yes	No	Yes	No
California	X		X	
Colorado	X		X	
Connecticut	X		X	
Delaware				
District of Columbia	X		X	
Florida	X		X	
Georgia				
Hawaii		0		0
Idaho				0
Illinois	X			
Indiana	X		X	
Iowa	X			
Kansas		0		0
Kentucky		0		0
Louisiana		0		0
Maine	X			0
Maryland	X		X	
Massachusetts			X	
Michigan	X		X	
Minnesota				
Mississippi		0		
Missouri		0		0
Montana		0		
Nebaska	X			
Nevada	X		0	
New Hampshire	X			
New Jersey	X		X	
New Mexico				0
New York	X		X	
North Carolina	0			
North Dakota		0		
Ohio		0		0
Oklahoma		0		
Oregon	X		X	
Pennsylvania	X		X	
Rhode Island				
South Carolina	X		X	
South Dakota		0		0
Tennessee		0	X	
Texas	X		X	
Utah				
Vermont		0		
Virginia [1]				0
Washington	X			
West Virginia		0		0
Wisconsin	X		X	
Wyoming				
American Samoa				
Guam				
Puerto Rico		0		
Virgin Islands				
Total	24	17	18	15

[1] Employ and consultant.

For purposes of comparison, in 1983, New York had the largest budget with $31 million a year and, along with Texas, hired the largest number of employees—689. South Dakota receives about $483,000 a year and employs 15 people, ranking as the smallest insurance department in the Nation. This has altered substantially

from 1977, where New York had the largest budget with $19 million a year and hired the most employees—694. South Dakota and Hawaii were the smallest departments that year; each received about $250,000 and employed 14 people.

In terms of salary, New Jersey continues to rank first, paying its commissioner $70,000 in 1983 and $49,000 in 1977. New York is second with $65,700 and $47,800 respectively. Also, the District of Columbia continues to be third, paying its commissioner just under $65,000 in 1983 and $49,000 in 1977. While Virginia paid the commissioner the least in 1983 with a salary of $31,500, South Dakota's insurance commissioner had the smallest salary in 1977, earning $22,700.

In terms of workload, the average insurance department had responsibility for overseeing $5 billion in premiums paid by State policyholders in 1983. This compares with an average of $3.5 billion in 1977. California and New York led the list in 1983, as they did in 1974. The recent figures are $25.3 billion and $23.5 billion, paid respectively by State policyholders in these States in 1983, as compared with $17.2 billion and $11.8 billion in 1977. The low in 1983 was Idaho with $24 million, as compared to New Mexico in 1977, which collected $15.3 million in annual premiums.

Section II of the questionnaire sought to determine the basic powers and duties of the State commission on insurance; the nature of the commission's authority to disapprove insurance forms if policies represented therein were deemed excessive, inadequate or discriminatory; the number of health insurance policies reviewed by each insurance department in 1983, as well as the number of such policies actually approved in the same year.

In response to the 1984 questionnaire, six States told the subcommittee that they did not feel they have in place the regulatory tools needed to address marketing abuses in the sale of Medigap insurance. These States included Louisiana, Maryland, Montana, North Carolina, South Dakota, and Utah. This is a slight improvement over the 11 States that responded similarly in 1977—see table VII. Four States in 1984 told the subcommittee that they do not have the authority to disapprove insurance forms if premiums are deemed excessive, inadequate or unfairly discriminatory. These States include Louisiana, Maine, Missouri, and Washington. This compares to seven States in 1977 (see table VIII).

The average insurance department had the herculean task of reviewing an average of 7,705 health and accident policies or changes in existing policies before these forms could be sold in the State in 1983. The 1977 figure was a good deal lower at 6,127. The State of Illinois received the most forms for approval with 26,500, followed by Louisiana which received 25,000 policies for approval. This is less surprising than the 1977 figures which indicate that Idaho receives the most forms for approval with 14,002, followed by Florida and Missouri which received slightly more than 12,000 policies for approval. In 1983, Hawaii had the fewest policies filed for approval with 1,659, while in 1977, West Virginia had the fewest with a total of 1,573 (see table IX). Almost all of these policies were approved by the commissioner (see table X).

TABLE VII.—STATE COMMISSIONERS WHO AGREE WITH STATEMENT, "STATES ALREADY HAVE REGULATORY TOOLS IN PLACE THAT ARE ADEQUATE TO ADDRESS MARKETING ABUSES"

	1984		1977	
	Yes	No	Yes	No
Alabama	X			
Alaska				
Arizona	X			
Arkansas	X			0
California	X		X	
Colorado	X		X	
Connecticut	X			0
Delaware	X			
District of Columbia	X			0
Florida				0
Georgia	X		X	
Hawaii	X		X	
Idaho				0
Illinois			X	
Indiana	X		X	
Iowa	X		X	
Kansas	X		X	
Kentucky	X		X	
Louisiana		0		
Maine			X	
Maryland		0		
Massachusetts	X			0
Michigan	X		X	
Minnesota				0
Mississippi	X		X	
Missouri	X		X	
Montana		0		
Nebraska	X			
Nevada	X		X	
New Hampshire	X		X	
New Jersey	X			0
New Mexico	X		X	
New York	X		X	
North Carolina		0	X	
North Dakota	X			0
Ohio	X		X	
Oklahoma				0
Oregon	X		X	
Pennsylvania	X		X	
Rhode Island	X		X	
South Carolina	X		X	
South Dakota		0	X	
Tennessee				0
Texas	X		X	
Utah		0	X	
Vermont	X		X	
Virginia	X			
Washington	X		X	
West Virginia	X		X	
Wisconsin	X		X	
Wyoming	X		X	
American Samoa				
Guam				
Puerto Rico	X			
Virgin Islands				
Total	38	6	31	11

TABLE VIII.—STATES WITH AUTHORITY TO DISAPPROVE INSURANCE FORMS IF PREMIUMS ARE DEEMED EXCESSIVE, INADEQUATE OR UNFAIRLY DISCRIMINATORY

	1984		1977	
	Yes	No	Yes	No
Alabama	X			0
Alaska				
Arizona	X		X	
Arkansas	X	0	X	
California	X		X	
Colorado	X		X	
Connecticut	X		X	
Delaware			X	
District of Columbia	X		X	
Florida	X		X	
Georgia			X	
Hawaii	X		X	
Idaho				0
Illinois	X			0
Indiana	X		X	
Iowa	X		X	
Kansas	X		X	
Kentucky	X		X	
Louisiana		0		
Maine		0	X	
Maryland	X		X	
Massachusetts			X	
Michigan	X		X	
Minnesota			X	
Mississippi	X		X	
Missouri		0	X	
Montana	X			
Nebaska	X			
Nevada	X		X	
New Hampshire	X			
New Jersey	X		X	
New Mexico			X	
New York	X		X	
North Carolina	X		X	
North Dakota	X			0
Ohio	X		X	
Oklahoma				0
Oregon	X		X	
Pennsylvania	X		X	
Rhode Island			X	
South Carolina	X		X	
South Dakota	X		X	
Tennessee	X		X	
Texas	X			0
Utah			X	
Vermont	X		X	
Virginia	X			0
Washington		0	X	
West Virginia	X		X	
Wisconsin	X		X	
Wyoming	X		X	
American Samoa				
Guam				
Puerto Rico	X			
Virgin Islands				
Total	38	4	39	7

TABLE IX.—HOW MANY ACCIDENT/HEALTH INSURANCE POLICIES OR CHANGES DID YOUR OFFICE REVIEW?

	1983	1982	1981	977
Alabama	4,560	NA	NA	NA
Alaska	NA	NA	NA	NA
Arizona	12,694	17,454	18,258	7,754
Arkansas	13,356	NA	NA	2,236
California	NA	NA	NA	4,471
Colorado	10,351	11,926	10,492	NA
Connecticut	1,716	2,371	2,693	5,000
Delaware	5,000	NA	NA	NA
District of Columbia	12,505	11,400	11,800	3,700
Florida	2,580	NA	NA	12,118
Georgia	6,703	5,813	6,104	NA
Hawaii	1,659	2,487	890	NA
Idaho	NA	NA	NA	4,002
Illinois	26,500	26,000	25,500	NA
Indiana	5,768	9,929	11,578	8,423
Iowa	1,981	2,301	1,898	NA
Kansas	13,494	21,859	18,998	5,517
Kentucky	9,100	6,200	5,500	6,171
Louisiana	25,000	23,000	22,000	12,000
Maine	NA	NA	NA	NA
Maryland	14,550	12,875	11,760	6,503
Massachusetts	NA	NA	NA	4,000
Michigan	0	0	0	2,481
Minnesota	NA	NA	NA	7,276
Mississippi	NA	NA	NA	NA
Missouri	16,628	16,517	16,592	12,023
Montana	NA	NA	NA	NA
Nebraska	NA	NA	NA	NA
Nevada	4,738	NA	NA	NA
New Hampshire	600	818	878	NA
New Jersey	5,200	4,500	6,100	6,320
New Mexico	NA	NA	NA	4,757
New York	3,020	2,307	1,876	8,216
North Carolina	5,100	4,800	4,900	4,463
North Dakota	4,899	5,576	NA	NA
Ohio	2,876	2,486	2,741	9,663
Oklahoma	11,000	NA	NA	NA
Oregon	NA	NA	NA	6,259
Pennsylvania	6,329	8,677	6,025	6,625
Rhode Island	NA	NA	NA	NA
South Carolina	4,000	4,000	4,000	3,401
South Dakota	6,000	NA	NA	1,546
Tennessee	10,040	12,254	8,118	5,041
Texas	9,921	16,052	11,947	3,316
Utah	12,945	13,119	10,578	4,000
Vermont	6,200	6,200	5,800	NA
Virginia	8,157	9,611	6,966	5,871
Washington	2,098	1,686	1,533	NA
West Virginia	3,349	1,471	1,002	1,573
Wisconsin	2,183	1,719	1,695	5,200
Wyoming	NA	NA	NA	NA
American Samoa				
Guam				
Puerto Rico	NA	NA	NA	NA
Virgin Islands				
Total	292,800	265,408	238,222	179,926
Average	7,705	8,562	7,941	5,804

TABLE X.—HOW MANY OF THESE POLICIES (OR CHANGES) DID YOU APPROVE IN 1983? IN 1977?

	1983	1982	1981	1977
Alabama	NA	NA	NA	NA
Alaska	NA	NA	NA	NA
Arizona	10,657	17,264	16,621	7,246
Arkansas	4,474	NA	NA	NA
California	NA	NA	NA	NA
Colorado	10,351	11,926	10,492	NA
Connecticut	1,327	1,400	1,812	4,500
Delaware	NA	NA	NA	NA
District of Columbia	11,700	10,700	11,100	3,500
Florida	2,019	NA	NA	6,626
Georgia	NA	NA	NA	NA
Hawaii	NA	NA	NA	NA
Idaho	NA	NA	NA	11,397
Illinois	22,970	22,570	22,000	NA
Indiana	4,446	6,132	7,401	4,090
Iowa	NA	NA	NA	NA
Kansas	9,533	10,352	9,769	4,611
Kentucky	8,500	5,850	5,140	4,264
Louisiana	(85%) 21,250	(85%) 19,550	(85%) 18,700	NA
Maine	NA	NA	NA	NA
Maryland	9,750	8,115	7,063	NA
Massachusetts	NA	NA	NA	1,800
Michigan	(100%) 0	(100%) 0	(100%) 0	NA
Minnesota	NA	NA	NA	NA
Mississippi	NA	NA	NA	NA
Missouri	13,146	7,456	6,084	7,080
Montana	NA	NA	NA	NA
Nebraska	3,177	1,627	NA	NA
Nevada	NA	NA	NA	NA
New Hampshire	NA	NA	NA	NA
New Jersey	(53%) 2,756	(46%) 2,070	(35%) 2,135	2,698
New Mexico	NA	NA	NA	4,700
New York	1,153	947	705	7,359
North Carolina	4,300	4,000	4,200	3,772
North Dakota	4,650	5,100	NA	NA
Ohio	2,610	2,291	2,028	9,134
Oklahoma	NA	NA	NA	NA
Oregon	NA	NA	NA	5,826
Pennsylvania	4,049	4,967	3,424	4,302
Rhode Island	NA	NA	NA	NA
South Carolina	e. 3,500	e. 3,500	e. 3,500	2,276
South Dakota	NA	NA	NA	NA
Tennessee	3,747	4,925	3,238	3,252
Texas	7,815	12,867	9,597	1,576
Utah	14,887	15,087	12,165	3,900
Vermont	(25%) 1,500	(30%) 1,860	(25%) 1,450	NA
Virginia	NA	NA	NA	4,676
Washington	1,909	1,547	1,406	NA
West Virginia	1,576	1,087	869	1,144
Wisconsin	1,898	1,495	1,474	5,050
Wyoming	NA	NA	NA	NA
American Samoa	NA	NA	NA	NA
Guam	NA	NA	NA	NA
Puerto Rico	NA	NA	NA	NA
Virgin Islands	NA	NA	NA	NA
Total	189,700	184,685	162,373	114,779
Average	6,541	6,840	6,495	4,782

HOW EFFECTIVE HAS STATE ENFORCEMENT BEEN?

The intent of most State laws is to protect the public from misrepresentations or the purchase of insurance which has little economic benefit. It is fair to say, based on the subcommittee's review of all the State laws, that most States have fairly wide authority to approve or disapprove policies offered for sale. The remaining question that the subcommittee sought to determine in section IV of the 1984 questionnaire was, "Which States have exercised that authority and in what specific ways?" To answer this question, the subcommittee asked State insurance departments whehter they had regulations covering the following aspects of health insurance policies in general (and Medicare supplemental policies in particular) as taken from the NAIC model bill. The following is an analysis of the States' response to the subcommittee inquiry:

A. Terms of renewability

In 1984, 41 States reported they had standards in effect relating to the terms of renewable insurance policies. Only 20 States reported having standards for renewability in 1977 (see table XI).

B. Initial and subsequent conditions of eligibility

Thirty-six States had regulations relating to the initial or subsequent conditions of eligibility for policies in 1984. This compares with 16 States reporting having similar regulations in 1977 (see table XII).

C. Nonduplication of coverage provisions

Thirty-four States reported regulations which spell out that insurance policies should not contain duplications of coverage provisions. Only 23 States had similar provisions in 1977 (see table XIII).

D. Readability

Thirty-four States answered that they had minimum standards in effect relating to readability. What this means is that policies must be written in "plain English," that there should be an absence of "legalese" and 150-word sentences. This standard is particularly important to the elderly who find it difficult to plow through Medicare forms, much less the fine print of insurance policies. Fifteen States had regulations relating to readability in 1977 (see table XIV).

E. Size of print

Another regulation which can be very important to the elderly, concerns the size of print used in policies. Some 39 States require that companies not print policies in small type in 1984, as compared to only 25 States in 1977. The most common regulation requires companies to use a minimum of 10-point type.

TABLE XI.—STATES WITH REGULATIONS REGARDING TERMS OF RENEWABILITY

	Yes	No
Alabama	1	X
Alaska		

TABLE XI.—STATES WITH REGULATIONS REGARDING TERMS OF RENEWABILITY—Continued

	Yes	No
Arizona	X	
Arkansas	X	
California	X	
Colorado	X	
Connecticut	X	
Delaware		0
District of Columbia	X	
Florida	X	
Georgia	X	
Hawaii	X	
Idaho		
Illinois	X	
Indiana	X	
Iowa	X	
Kansas	X	
Kentucky	X	
Louisiana	X	
Maine		
Maryland	X	
Massachusetts		
Michigan	X	
Minnesota		
Mississippi	X	
Missouri		0
Montana	X	
Nebraska	X	
Nevada	X	
New Hampshire	X	
New Jersey	X	
New Mexico	X	
New York	X	
North Carolina		0
North Dakota	X	
Ohio	X	
Oklahoma		0
Oregon	X	
Pennsylvania	X	
Rhode Island	X	
South Carolina	X	
South Dakota		
Tennessee	X	
Texas	X	
Utah	X	
Vermont	X	
Virginia	X	
Washington		
West Virginia	X	
Wisconsin	X	
Wyoming	X	
American Samoa		
Guam		
Puerto Rico	X	
Virgin Islands		
Total	41	4

TABLE XII.—STATES WITH REGULATIONS REGARDING INITIAL AND SUBSEQUENT CONDITIONS OF ELIGIBILITY

	Yes	No
Alabama		X
Alaska		
Arizona		X
Arkansas		X
California		X
Colorado	0	
Connecticut		X
Delaware	0	
District of Columbia		X
Florida		X
Georgia		X
Hawaii	0	
Idaho		
Illinois		X
Indiana		X
Iowa		X
Kansas		X
Kentucky		X
Louisiana		X
Maine		
Maryland		X
Massachusetts		
Michigan		X
Minnesota		
Mississippi		X
Missouri	0	
Montana		X
Nebraska	0	
Nevada		X
New Hampshire		X
New Jersey		X
New Mexico		X
New York		X
North Carolina		X
North Dakota		X
Ohio		X
Oklahoma	0	
Oregon		X
Pennsylvania		X
Rhode Island		X
South Carolina		X
South Dakota		
Tennessee		X
Texas		X
Utah		X
Vermont		X
Virginia		X
Washington		
West Virginia		X
Wisconsin		
Wyoming	0	
American Samoa		
Guam		
Puerto Rico		X
Virgin Islands		
Total	36	7

TABLE XIII.—STATES WITH REGULATIONS REGARDING NON-DUPLICATION OF COVERAGE PROVISIONS

	Yes	No
Alabama	X	
Alaska		
Arizona	X	
Arkansas	X	
California	X	
Colorado		0
Connecticut		0
Delaware		0
District of Columbia		
Florida	X	
Georgia	X	
Hawaii		0
Idaho		
Illinois	X	
Indiana	X	
Iowa	X	
Kansas	X	
Kentucky	X	
Louisiana	X	
Maine		
Maryland	X	
Massachusetts		
Michigan		0
Minnesota		
Mississippi	X	
Missouri	X	
Montana	X	
Nebraska	X	
Nevada	X	
New Hampshire	X	
New Jersey	X	
New Mexico	X	
New York	X	
North Carolina		0
North Dakota	X	
Ohio		0
Oklahoma	X	
Oregon		0
Pennsylvania	X	
Rhode Island	X	
South Carolina	X	
South Dakota		
Tennessee	X	
Texas		0
Utah	X	
Vermont	X	
Virginia		0
Washington		
West Virginia	X	
Wisconsin	X	
Wyoming	X	
American Samoa		
Guam		
Puerto Rico	X	
Virgin Islands		
Total	34	10

TABLE XIV.—STATES WITH READABILITY STANDARDS

	1984	1977
Alabama	X	
Alaska		
Arizona	X	X
Arkansas	X	X
California	X	X
Colorado	X	
Connecticut	X	
Delaware	X	
District of Columbia	X	
Florida	X	X
Georgia	X	
Hawaii	X	
Idaho		
Illinois		
Indiana	X	
Iowa		
Kansas		
Kentucky	X	
Louisiana		
Maine		
Maryland	X	X
Massachusetts		X
Michigan		X
Minnesota		X
Mississippi	X	
Missouri		
Montana	X	
Nebraska	X	
Nevada	X	
New Hampshire		X
New Jersey	X	
New Mexico	X	X
New York	X	
North Carolina	X	
North Dakota	X	
Ohio	X	
Oklahoma		
Oregon	X	X
Pennsylvania		X
Rhode Island		
South Carolina	X	X
South Dakota		
Tennessee	X	
Texas	X	X
Utah	X	
Vermont	X	
Virginia	X	X
Washington		
West Virginia	X	
Wisconsin	X	X
Wyoming	X	
American Samoa		
Guam		
Puerto Rico	X	
Virgin Islands		
Total	34	16

TABLE XV.—STATES WITH SIZE OF PRINT REGULATIONS

	Yes	No
Alabama	X	
Alaska		
Arizona	X	X
Arkansas	X	X
California	X	X
Colorado	X	X
Connecticut	X	X
Delaware		
District of Columbia	X	
Florida	X	X
Georgia	X	
Hawaii	X	[1] X
Idaho		
Illinois		
Indiana	X	X
Iowa	X	
Kansas	X	X
Kentucky	X	X
Louisiana	X	X
Maine		
Maryland	X	
Massachusetts		X
Michigan	X	X
Minnesota		X
Mississippi	X	X
Missouri	X	
Montana	X	
Nebraska	X	
Nevada	X	
New Hampshire	X	X
New Jersey	X	
New Mexico		
New York	X	X
North Carolina	X	X
North Dakota	X	
Ohio	X	
Oklahoma		
Oregon	X	
Pennsylvania	X	X
Rhode Island	X	
South Carolina	X	X
South Dakota		
Tennessee	X	[1] X
Texas	X	X
Utah		[1] X
Vermont	X	
Virginia	X	
Washington		
West Virginia	X	
Wisconsin	X	X
Wyoming	X	X
American Samoa		
Guam		
Puerto Rico	X	
Virgin Islands		
Total	39	25

[1] Specified in Statutes.

F. Preexisting conditions

A preexisting condition is an illness that was in evidence before a policy was written.

For senior citizens it is quite common for an insurance company to deny payment, saying the injury or illness began before the policy was written. These escape clauses are a major source of problems and complaints from senior citizens.

A 1974 report from the Senate Special Committee on Aging comments:

> An example would include the following case: Mr. X suffers from arthritis in his knee and has been suffering from arthritis for some time. After the effective date of his insurance policy, an intense arthritic pain in his knee causes him to lose his balance. He falls and breaks his leg. With an ironclad preexisting condition clause, Mr. X's insurance policy would not pay for any hospital or medical costs incurred for his broken leg.
>
> Because persons 65 and over may have multiple health problems, a preexisting condition clause, in the extreme form presented in the case of Mr. X, could provide no coverage at all to many aged persons. Therefore, the preexisting condition clause has become a very critical issue in health policies for the elderly.

Every State department of insurance studied in the course of this working paper considered problems related to preexisting conditions among the most numerous, the most serious, and the most difficult for the elderly.

The departments see the solution, or at least partial solution, in the shortening of the period of the preexisting condition. The most favorable solution, at least to some of the elderly, would be elimination of preexisting condition clauses entirely. In such instances, regardless of what illness or injury occurred prior to the policy, the claim would be paid.

However, as was pointed out by one of the commissioners, elimination of the preexisting condition clause in its entirety would raise the premium costs for all the elderly. Rates cannot be discriminatory. Premiums would be identical for all purchasers of the same policy. The well elderly would be paying higher premiums and that would be inequitable because, to some extent, they would be paying for the ill elderly.

The most frequent solution for the preexisting condition problem used by the departments of insurance is to shorten the condition period.

In its July 1978 questionnaire, the House Select Committee on Aging staff learned that only 17 States had regulations limiting preexisting conditions in any way. Specifically, with respect to Medicare supplementary health insurance policies, New Mexico and North Carolina reported that they barred the use of such clauses completely. California and Colorado limited their use to 6 months—so after 6 months had elapsed the company could not excuse its liability on the rationale that the current injury or illness was related to something the insured had before he or she

bought the policy. Kansas, Massachusetts, and North Dakota reported 1-year limitations. The remaining 10 States had limitations averaging 2 years.

By 1984, 41 States had regulations limiting preexisting conditions (see table XVI).

G. Termination of insurance

Twenty-one States reported having regulations with respect to the terms and conditions under which policies may be terminated by both insurance companies and their agents in 1977. Thirty-nine States had such a regulation in 1984 (see table XVII).

H. Exceptions

Twenty States regulated the use of exceptions—the excuses which insurance companies can use for failing to pay claims—In 1983, 43 States had regulations relating to the use of exceptions (see table XVIII).

I. Requirements for replacement

In 1977, 17 States reported standards which spell out the obligations which insurance companies and their agents must meet before they replace a policy already in existence. By 1984, 43 States had such regulations in place (see table XIX).

TABLE XVI.—STATES LIMITING PREEXISTING CONDITION CLAUSES

	1984		1977	
	Yes	No	Yes	No
Alabama	X			
Alaska				
Arizona	X			0
Arkansas	X		X	
California	X		X	
Colorado	X		X	
Connecticut	X			0
Delaware		0		0
District of Columbia	X			0
Florida	X			0
Georgia	X			0
Hawaii	X			0
Idaho			X	
Illinois	X			0
Indiana	X			0
Iowa	X		X	
Kansas	X		X	
Kentucky	X		X	
Louisiana	X			0
Maine				0
Maryland	X		X	
Massachusetts			X	
Michigan	X			0
Minnesota			X	
Mississippi	X		X	
Missouri	X		X	
Montana	X			
Nebraska	X			
Nevada	X			0
New Hampshire	X		X	
New Jersey	X			0

TABLE XVI.—STATES LIMITING PREEXISTING CONDITION CLAUSES—Continued

	1984		1977	
	Yes	No	Yes	No
New Mexico	X		X	
New York	X			0
North Carolina	X		X	
North Dakota	X		X	
Ohio	X			0
Oklahoma				0
Oregon		0		0
Pennsylvania	X			0
Rhode Island		0	X	
South Carolina	X		X	
South Dakota				0
Tennessee	X			0
Texas	X			0
Utah	X			0
Vermont	X			0
Virginia	X			0
Washington				0
West Virginia	X			0
Wisconsin	X			0
Wyoming	X			0
American Samoa				
Guam				
Puerto Rico	X			
Virgin Islands				
Total	41	3	17	29

TABLE XVII.—STATES WITH REGULATIONS REGARDING TERMINATION OF INSURANCE

	Yes	No
Alabama	X	
Alaska		
Arizona	X	
Arkansas	X	
California	X	
Colorado	X	
Connecticut	X	
Delaware	X	0
District of Columbia	X	
Florida	X	
Georgia	X	
Hawaii		0
Idaho		
Illinois	X	
Indiana	X	
Iowa	X	
Kansas	X	
Kentucky	X	
Louisiana	X	
Maine		
Maryland	X	
Massachusetts		
Michigan	X	
Minnesota		
Mississippi	X	
Missouri		0
Montana	X	
Nebraska	X	
Nevada	X	

TABLE XVII.—STATES WITH REGULATIONS REGARDING TERMINATION OF INSURANCE—Continued

	Yes	No
New Hampshire	X	
New Jersey	X	
New Mexico	X	
New York	X	
North Carolina		
North Dakota	X	
Ohio	X	
Oklahoma	X	
Oregon		0
Pennsylvania	X	
Rhode Island		0
South Carolina	X	
South Dakota		
Tennessee	X	
Texas	X	
Utah	X	
Vermont	X	
Virginia	X	
Washington		
West Virginia	X	
Wisconsin	X	
Wyoming	X	
American Samoa		
Guam		
Puerto Rico	X	
Virgin Islands		
Total	39	5

TABLE XVIII.—STATES REGULATING THE USE OF EXCEPTIONS

	Yes	No
Alabama	X	
Alaska		
Arizona	X	
Arkansas	X	
California	X	
Colorado	X	
Connecticut	X	
Delaware		0
District of Columbia	X	
Florida	X	
Georgia	X	
Hawaii	X	
Idaho		
Illinois	X	
Indiana	X	
Iowa	X	
Kansas	X	
Kentucky	X	
Louisiana	X	
Maine		
Maryland	X	
Massachusetts		
Michigan	X	
Minnesota		
Mississippi	X	
Missouri	X	
Montana	X	
Nebraska	X	

TABLE XVIII.—STATES REGULATING THE USE OF EXCEPTIONS—Continued

	Yes	No
Nevada	X	
New Hampshire	X	
New Jersey	X	
New Mexico	X	
New York	X	
North Carolina	X	
North Dakota	X	
Ohio	X	
Oklahoma	X	
Oregon		0
Pennsylvania	X	
Rhode Island	X	
South Carolina	X	
South Dakota		
Tennessee	X	
Texas	X	
Utah	X	
Vermont	X	
Virginia	X	
Washington		
West Virginia	X	
Wisconsin	X	
Wyoming	X	
American Samoa		
Guam		
Puerto Rico	X	
Virgin Islands		
Total	43	2

TABLE XIX.—STATES WITH STANDARDS FOR POLICY REPLACEMENTS

	Yes	No
Alabama	X	
Alaska		
Arizona	X	
Arkansas	X	
California	X	
Colorado	X	
Connecticut	X	
Delaware	X	
District of Columbia	X	
Florida	X	
Georgia	X	
Hawaii	X	
Idaho		
Illinois	X	
Indiana	X	
Iowa	X	
Kansas	X	
Kentucky	X	
Louisiana	X	
Maine		
Maryland	X	
Massachusetts		
Michigan	X	
Minnesota		
Mississippi	X	
Missouri	X	
Montana	X	

TABLE XIX.—STATES WITH STANDARDS FOR POLICY REPLACEMENTS—Continued

	Yes	No
Nebraska	X	
Nevada	X	
New Hampshire	X	
New Jersey	X	
New Mexico	X	
New York		0
North Carolina	X	
North Dakota	X	
Ohio	X	
Oklahoma	X	
Oregon		0
Pennsylvania	X	
Rhode Island	X	
South Carolina	X	
South Dakota		
Tennessee	X	
Texas	X	
Utah	X	
Vermont	X	
Virginia	X	
Washington		
West Virginia	X	
Wisconsin	X	
Wyoming	X	
American Samoa		
Guam		
Puerto Rico	X	
Virgin Islands		
Total	43	2

J. Key terms

The way in which an insurance company defines the key terms that it uses in its insurance policies can make a tremendous difference to the policyholder. Some insurance companies have used restrictive definitions as a subtle and hidden excuse for limiting their liability for claims. In order to head off this type of abuse, 21 States had promulgated regulations by 1977 requiring companies to use standard definitions of such words as "injury," "total disability," "nervous disorder," "guaranteed renewable," and "noncancellable," By 1984, 41 States has promulgated such regulations (see table XX).

K. Use of approved graphics

Another positive innovation which some States have adopted concerns the use of approved graphics which show the consumer the gaps in the Medicare Program and exactly how these gaps will be affected by the policy to be purchased. Some States require the use of such guides not only on initial purchases but any time an agent seeks to replace a policy already held by the insured. The agent must compare (by means of approved graphics) the benefits of the existing policy and the proposed new policy for the customer. Failure to use such graphics is grounds to have an agent's license revoked.

In 1986, in only 2 of the 12 interviews with insurance agents did the agent compare our senior citizen investigator's coverage with the new policy he attempted to sell her. An approved form used by an agent in Virginia appears on page 144.

Only seven States required that agents use approved consumer guides at the time of the proposed sale of Medicare supplemental health insurance policies in 1977. Today, 41 States have the requirement by regulation (see table XXI).

L. Minimum coverage requirements

Thirty-three States reported having minimum benefit laws in 1977. Such laws permit the disapproval of a policy "if, irrespective of the premium charged therefore, any benefit of the policy is, or the benefits of the policy as a whole are, not sufficient to be of real economic value to the insured," according to California statute. The subcommittee found that 40 States had such laws in place by 1984 (see table XXII).

M. Refund requirement

One regulation which several States have found of great benefit to the consumer is a "no-loss right to cancellation." This is the technical name for giving the consumer a 10- to 15-day free look at a policy. If at any time during the 15-day period the customer decides that he/she does not want the policy he/she has purchased, he/she may return it to the company and have his/her money returned in full. Barely half of the States—26—had regulations giving the consumer this valuable protection in 1977. By 1984, 36 States provided such consumer protection (see table XXIII).

In addition to the regulations reviewed above by the subcommittee in 1977 and 1984, the subcommittee sought to determine which States had acted to promulgate additional regulations recommended in the 1980 NAIC model for State regulation of Medigap insurance, which included regulations relating to probation periods, limitations specified in policies, reductions, eliminations, recurrent conditions, cancellation of entire policies in force, disclosure requirements, and statements of major benefit gaps in Medicare Parts A and B, without parallel description of supplemental benefits. The subcommittee found that since 1980, at least one-half of all States had promulgated regulations in the aforementioned areas of regulatory concern.

TABLE XX.—STATES REGULATING THE DEFINITIONS OF SUCH KEY TERMS AS: HOSPITAL, ACCIDENT, INJURY, PHYSICIAN ACCIDENTAL MEANS, TOTAL DISABILITY, NERVOUS DISORDER, GUARANTEED RENEWABLE AND NON-CANCELLABLE

	1984	1977
Alabama	X	
Alaska		
Arizona	X	
Arkansas	X	X
California	X	X
Colorado	X	X
Connecticut	X	X
Delaware		
District of Columbia	X	

TABLE XX.—STATES REGULATING THE DEFINITIONS OF SUCH KEY TERMS AS: HOSPITAL, ACCIDENT, INJURY, PHYSICIAN ACCIDENTAL MEANS, TOTAL DISABILITY, NERVOUS DISORDER, GUARANTEED RENEWABLE AND NON-CANCELLABLE—Continued

	1984	1977
Florida	X	X
Georgia	X	
Hawaii	X	
Idaho		X
Illinois	X	X
Indiana	X	
Iowa	X	
Kansas	X	
Kentucky	X	X
Louisiana	X	
Maine		
Maryland	X	X
Massachusetts		X
Michigan	X	
Minnesota		X
Mississippi	X	
Missouri	X	
Montana	X	
Nebraska	X	
Nevada	X	
New Hampshire	X	X
New Jersey	X	
New Mexico	X	X
New York	X	X
North Carolina	X	X
North Dakota	X	
Ohio	X	
Oklahoma		
Oregon		
Pennsylvania	X	X
Rhode Island		
South Carolina	X	
South Dakota		
Tennessee	X	
Texas	X	X
Utah	X	
Vermont	X	
Virginia	X	
Washington		X
West Virginia	X	X
Wisconsin	X	X
Wyoming	X	X
American Samoa		
Guam		
Puerto Rico	X	
Virgin Islands		
Total	41	21

TABLE XXI.—STATES REQUIRING THAT THE PROSPECTIVE PURCHASER BE GIVEN A FORM SHOWING COVERAGE AVAILABLE UNDER MEDICARE AND MEDICAID AND HOW THE POLICY WOULD FILL THE GAPS

	Yes	No
Alabama	X	
Alaska		
Arizona	X	

TABLE XXI.—STATES REQUIRING THAT THE PROSPECTIVE PURCHASER BE GIVEN A FORM SHOWING COVERAGE AVAILABLE UNDER MEDICARE AND MEDICAID AND HOW THE POLICY WOULD FILL THE GAPS—Continued

	Yes	No
Arkansas	X	
California	X	
Colorado	X	
Connecticut	X	
Delaware		0
District of Columbia	X	
Florida	X	
Georgia	X	
Hawaii	X	
Idaho		
Illinois	X	
Indiana	X	
Iowa		0
Kansas	X	
Kentucky	X	
Louisiana	X	
Maine		
Maryland	X	
Massachusetts		
Michigan	X	
Minnesota		
Mississippi	X	
Missouri	X	
Montana	X	
Nebraska	X	
Nevada	X	
New Hampshire	X	
New Jersey	X	
New Mexico	X	
New York	X	
North Carolina	X	
North Dakota	X	
Ohio	X	
Oklahoma		
Oregon		0
Pennsylvania	X	
Rhode Island	X	
South Carolina	X	
South Dakota		
Tennessee	X	
Texas	X	
Utah	X	
Vermont	X	
Virginia	X	
Washington		
West Virginia	X	
Wisconsin	X	
Wyoming	X	
American Samoa		
Guam		
Puerto Rico	X	
Virgin Islands		
Total	41	2

TABLE XXII.—STATES REGULATING MINIMUM COVERAGE REQUIREMENTS

	Yes	No
Alabama	X	
Alaska		
Arizona	X	
Arkansas	X	
California	X	
Colorado	X	
Connecticut	X	
Delaware		0
District of Columbia	X	
Florida	X	
Georgia	X	
Hawaii	X	
Idaho		
Illinois		
Indiana	X	
Iowa	X	
Kansas	X	
Kentucky	X	
Louisiana	X	
Maine		
Maryland	X	
Massachusetts		
Michigan	X	
Minnesota		
Mississippi	X	
Missouri	X	
Montana	X	
Nebraska	X	
Nevada	X	
New Hampshire	X	
New Jersey	X	
New Mexico		
New York	X	
North Carolina	X	
North Dakota	X	
Ohio	X	
Oklahoma		
Oregon		0
Pennsylvania	X	
Rhode Island		0
South Carolina	X	
South Dakota		
Tennessee	X	
Texas	X	
Utah	X	
Vermont	X	
Virginia	X	
Washington		
West Virginia	X	
Wisconsin	X	
Wyoming	X	
American Samoa		
Guam		
Puerto Rico	X	
Virgin Islands		
Total	40	3

TABLE XXIII.—STATES WITH REFUND REQUIREMENTS

	Yes	No
Alabama	X	
Alaska		
Arizona	X	
Arkansas	X	
California	X	
Colorado	X	
Connecticut		0
Delaware		0
District of Columbia	X	
Florida	X	
Georgia	X	
Hawaii		0
Idaho		
Illinois	X	
Indiana	X	
Iowa	X	
Kansas	X	
Kentucky	X	
Louisiana	X	
Maine		
Maryland	X	
Massachusetts		
Michigan	X	
Minnesota		
Mississippi	X	
Missouri		0
Montana	X	
Nebraska	X	
Nevada	X	
New Hampshire	X	
New Jersey	X	
New Mexico	X	
New York	X	
North Carolina		0
North Dakota	X	
Ohio	X	
Oklahoma		
Oregon		0
Pennsylvania	X	
Rhode Island	X	
South Carolina	X	
South Dakota		
Tennessee	X	
Texas		0
Utah		0
Vermont	X	
Virginia	X	
Washington		
West Virginia	X	
Wisconsin	X	
Wyoming	X	
American Samoa		
Guam		
Puerto Rico	X	
Virgin Islands		
Total	36	8

SAMPLE OF FORM SHOWING COVERAGE AVAILABLE UNDER MEDICARE AND MEDICAID AND HOW THE POLICY WOULD FILL THE GAPS

SUMMARY OF MEDICARE BENEFITS AND POLICY BENEFITS

Inpatient Hospital Benefits, (Part A of Medicare). Benefits are paid for covered hospital charges for hospital room and board and miscellaneous services during each "benefit period" as follows:

Day of confinement	Medicare now pays	Policy pays
Days 1–60 each benefit period	Covered charges, but not the first $144	.....
Days 61–90 each benefit period	Covered charges except $36 a day	.....
Days 91–150 while "lifetime reserve" remains	Covered charges except $72 a day	.....

Skilled nursing facility Confinement Benefits. (Part A of Medicare). Benefits are paid for covered skilled nursing facility charges, if the patient is an inpatient in an approved skilled nursing facility and confinement begins within 14 days of a hospital stay of at least 3 days for the same injury or sickness, as follows:

Day of confinement	Medicare now pays	Policy pays
Days 1–20 each "benefit period"	All covered charges	.....
Days 21–100 each "benefit period"	Covered charges except $18.00 a day	.....

Medical Benefits (Part B of Medicare). Benefits are provided for "reasonable charges" for covered physician's services, medical supp'ies, and other covered services, each calendar year.

Medicare now pays	*Policy pays*
80% of the "reasonable charges" but not the first $60 each year	.....

The Summary shall also contain:

(a) A description of any other benefits provided by the policy or subscriber contract.

(b) A description of the exceptions, reductions and limitations contained in the policy or subscriber contract.

(c) A statement that the Summary is only a brief summary of certain policy or subscriber contract provisions, and is not a part of the contract of insurance. The policy (or subscriber contract) itself set forth the rights and obligations of the insured (or subscriber) and the insurer (or plan).

(d) A statement that Medicare Benefits change from time to time, according to Federal Law and with Rules and Regulations of the Social Security Administration.

(e) The name of the Insurer or Health Care Plan and address must appear on the Summary of Benefits.

OTHER STATE EFFECTIVENESS MEASURES

Section IV of the 1984 questionnaire also sought to determine whether the States had regulations relating to permissible (as opposed to deceptive) advertising of health/accident policies; whether they have mandatory review procedures for advertisements which related to insurance policies sold by mail; whether the State has a minimum loss ratio for various classes of health insurance, and specifically what their minimum loss ratio was for Medicare supplemental policies; whether the States have laws requiring unit

pricing of Medicare policies so consumers can do some comparison shopping; and whether their State requires agents to provide the client with a State-approved guide at the time of sale. The following is an analysis of the State's response to the subcommittee's inquiry in this regard:

1. Permissible (as opposed to deceptive) advertising of health and accident policies.

Some 38 States in 1977 answered that they had regulations in place which detail the limit of permissible advertising with respect to health insurance policies. In practical application this means that in most States, companies can run any advertising they wish unless and until the State commissioners intervene. The State commissioner has the burden of stepping in after ads have been running and of proving the ads are contrary to law and regulations (see table XXIV).

2. Mandatory review procedures.

Some States have recognized advertising as a problem and have sought to put the burden of proof on the insurance company rather than the State commissioner. These States have mandatory review procedures which means that insurance companies must file their proposed advertising with the commissioner and gain approval before the ads can be used in the State. Through its questionnaire in 1978, the committee found that there were 14 States which had mandatory review regulations. By 1984, that number was cut in half. Only six States—Alabama, Arizona, Michigan, New Jersey, Oregon, Pennsylvania, and Puerto Rico—have mandatory review procedures for advertisements which relate to insurance policies sold by the mail in 1984 (see table XXV).

3. Minimum loss ratios.

There is no more important index to the economic value of an insurance policy than its loss ratio. The term has been defined many times in this report. Loss ratio refers to the amount of premiums collected by an insurance company which is returned to its insured in the form of paid claims. If, for example, for each dollar of premium income, the company returns 75 cents in benefits, the loss ratio is 75 percent.

Loss ratios provide some insight into the size of the premium in relation to the company's expenses—including amounts it pays its salesmen in commissions—and it provides insights into the claims-paying habits of the company. A very low loss ratio may indicate that a company is not paying legitimate claims. It is not uncommon for a company to pay its salesmen more in commissions than it does in claims to its insured.

Actual loss ratio experience for over 360 companies has been detailed in appendix E of this report.

Progressive States in growing numbers have sought to regulate minimum loss ratios.

Through its 1978 questionnaire, the committee learned that, while 20 States had regulations spelling out minimum loss ratios for various classes of health insurance, including Medicare supplemental policies, that number had increased to 44 in 1984 (see table XXVI). With respect to Medigap policies, in 1984, Massachusetts had the highest requirement—a 65 per-

cent loss ratio—while on the average other States had a 60 percent loss ratio. This means a company must return at least 60 percent (65 percent in the case of Massachusetts) of what it takes in to the insured in the form of benefits. While most States do have this standard, the States readily admit that they have no way of knowing whether policies sold in their boundaries conform to the regulation.

Each State that said it had minimum loss ratios was asked whether such requirements had the force of law, that is, were they promulgated in regulation or mandated by law or were the standards merely guidelines. The distinction is that legal liability attaches to failure to conform to law or regulations, and companies can be fined and their policies removed from the market in many cases. No liability attaches to companies who ignore guidelines.

Ten of the 44 States that reported minimum loss ratios said they were found in guidelines issued by the State insurance commissioner—again, these guidelines do not have the force of law (see table XXVII).

TABLE XXIV.—STATES WITH REGULATIONS RELATING TO PERMISSIBLE (AS OPPOSED TO DECEPTIVE) ADVERTISING OF HEALTH/ACCIDENT POLICIES

	1984		1977	
	Yes	No	Yes	No
Alabama	X		X	
Alaska				0
Arizona	X		X	
Arkansas		0	X	
California	X		X	
Colorado		0	X	
Connecticut	X			0
Delaware	X			0
District of Columbia	X			0
Florida	X			0
Georgia	X			0
Hawaii		0		0
Idaho			X	
Illinois	X			0
Indiana		0	X	
Iowa	X		X	
Kansas		0		0
Kentucky		0	X	
Louisiana	X		X	
Maine			X	
Maryland	X		X	
Massachusetts	X		X	
Michigan	X		X	
Minnesota			X	
Mississippi	X		X	
Missouri	X		X	
Montana		0	X	
Nebraska		0		
Nevada	X		X	
New Hampshire	X		X	
New Jersey	X			0
New Mexico	X		X	
New York	X		X	
North Carolina	X		X	
North Dakota	X			0

TABLE XXIV.—STATES WITH REGULATIONS RELATING TO PERMISSIBLE (AS OPPOSED TO DECEPTIVE) ADVERTISING OF HEALTH/ACCIDENT POLICIES—Continued

	1984		1977	
	Yes	No	Yes	No
Ohio	X		X	
Oklahoma	X		X	
Oregon	X			0
Pennsylvania	X			0
Rhode Island		0	X	
South Carolina	X		X	
South Dakota		X	X	
Tennessee	X		X	
Texas	X		X	
Utah	X		X	
Vermont		0	X	
Virginia		0	X	
Washington	X		X	
West Virginia	X		X	
Wisconsin	X		X	
Wyoming	X		X	
American Samoa				
Guam				
Puerto Rico	X			
Virgin Islands				
Total	37	11	37	13

TABLE XXV.—STATES WITH MANDATORY REVIEW PROCEDURES FOR ADVERTISEMENTS WHICH RELATE TO INSURANCE POLICIES SOLD BY MAIL

	1984		1977	
	Yes	No	Yes	No
Alabama	X			0
Alaska				0
Arizona	X		X	
Arkansas		0		0
California	(1)	(1)		
Colorado		0		0
Connecticut		0		0
Delaware		0		0
District of Columbia		0	X	
Florida		0		0
Georgia		0		0
Hawaii		0		0
Idaho			X	
Illinois		0		0
Indiana		0		0
Iowa		0		0
Kansas		0		0
Kentucky		0	X	
Louisiana		0		0
Maine		0		0
Maryland		0	X	
Massachusetts		0		0
Michigan	X		X	
Minnesota				0
Mississippi		0		0
Missouri		0		0
Montana		0	X	
Nebraska		0		

TABLE XXV.—STATES WITH MANDATORY REVIEW PROCEDURES FOR ADVERTISEMENTS WHICH RELATE TO INSURANCE POLICIES SOLD BY MAIL—Continued

	1984		1977	
	Yes	No	Yes	No
Nevada		0		0
New Hampshire		0		0
New Jersey	X		X	
New Mexico		0		0
New York		0		0
North Carolina		0	X	
North Dakota		0		0
Ohio		0		0
Oklahoma		0		0
Oregon	X		X	
Pennsylvania	X		X	
Rhode Island		0		0
South Carolina		0	X	
South Dakota		0		0
Tennessee		0		0
Texas		0		0
Utah		0		0
Vermont		0		0
Virginia		0		0
Washington		0	X	
West Virginia		0	X	
Wisconsin		0		0
Wyoming		0	X	
American Samoa				
Guam				
Puerto Rico	X			
Virgin Islands				
Total	7	41	15	35

[1] Has the authority to require review.

TABLE XXVI(a).—STATES WITH MINIMUM LOSS RATIOS FOR VARIOUS CLASSES OF HEALTH INSURANCE INCLUDING MEDICARE SUPPLEMENTAL POLICIES IN 1984

	No	Yes	Amount of minimum percent	Law or regulation	Guidelines
Alabama		X	60	X	
Alaska			NA		
Arizona		X	60	X	
Arkansas		X	60		X
California		X	NA	X	
Colorado		X	60	X	
Connecticut		X	65		
Delaware		X	NA		
District of Columbia		X	60	X	
Florida		X	60		X
Georgia		X	60	X	
Hawaii		X	60	X	
Idaho			NA		
Illinois	0		60		
Indiana		X	60		X
Iowa		X	60		
Kansas		X	60	X	
Kentucky		X	60	X	
Louisiana	0		60		
Maine		X	60	X	
Maryland		X	60	X	

TABLE XXVI(a).—STATES WITH MINIMUM LOSS RATIOS FOR VARIOUS CLASSES OF HEALTH INSURANCE INCLUDING MEDICARE SUPPLEMENTAL POLICIES IN 1984—Continued

	No	Yes	Amount of minimum percent	Law or regulation	Guidelines
Massachusetts		X	65	X	
Michigan		X	60	X	
Minnesota			NA		
Mississippi		X	60	X	
Missouri	0		60		
Montana		X	60	X	
Nebraska		X	60	X	
Nevada		X	60		X
New Hampshire		X	60	X	
New Jersey		X	65	X	X
New Mexico		X	60		X
New York		X	65	X	
North Carolina	0	X M-gap	60	X	
North Dakota		X	60	X	
Ohio		X	60	X	
Oklahoma		X	60	X	
Oregon		X	60	X	
Pennsylvania		X	60	X	
Rhode Island		X	60	X	
South Carolina		X	60		X
South Dakota		X	60		X
Tennessee		X	60	X	
Texas	0		60		X M-gap
Utah		X	60	X	
Vermont		X	60	X	
Virginia		X	60	X	
Washington		X	60	X	
West Virginia		X	60	X	
Wisconsin		X	60	X	
Wyoming		X	60	X	
American Samoa					
Guam					
Puerto Rico	0				
Virgin Islands					
Total	6	44		34	9

TABLE XXVI(b).—STATES WITH MINIMUM LOSS RATIOS FOR VARIOUS CLASSES OF HEALTH INSURANCE INCLUDING MEDICARE SUPPLEMENTAL POLICIES IN 1977

	No	Yes	Amount of minimum percent [1]	Law or regulation	Guidelines
Alabama	0				
Alaska	0				
Arizona	0				
Arkansas	0				
California		X	55	X	
Colorado		X		X	
Connecticut	0				
Delaware	0				
District of Columbia	0				
Florida	0				
Georgia	0				
Hawaii	0				
Idaho	0				
Illinois	0				
Indiana		X	55		X

TABLE XXVI(b).—STATES WITH MINIMUM LOSS RATIOS FOR VARIOUS CLASSES OF HEALTH INSURANCE INCLUDING MEDICARE SUPPLEMENTAL POLICIES IN 1977—Continued

	No	Yes	Amount of minimum percent [1]	Law or regulation	Guidelines
Iowa		X	55		X
Kansas		X			
Kentucky		X	60		X
Louisiana	0				
Maine		X			
Maryland		X	55		X
Massachusetts	0				
Michigan		X	65	X	X
Minnesota		X	50	X	X
Mississippi	0				
Missouri	0				
Montana	0				
Nebraska					
Nevada		X	60		
New Hampshire	0				
New Jersey		X	50		X
New Mexico	0				
New York		X	60	X	X
North Carolina	0				
North Dakota	0				
Ohio		X	50		X
Oklahoma		X			
Oregon	0				
Pennsylvania		X	50	X	
Rhode Island		X	60		
South Carolina		X	50		X
South Dakota	0				
Tennessee	0				
Texas	0				
Utah	0				
Vermont		X	50		X
Virginia	0				
Washington		X			
West Virginia	0				
Wisconsin		X	50		X
Wyoming	0				
American Samoa					
Guam					
Puerto Rico					
Virgin Islands					
Total	29	21		6	12

[1] 60 percent rate increase.

TABLE XXVII.—STATES WITH MINIMUM LOSS RATIOS MANDATED BY LAW, REGULATION OR GUIDELINES

	1984		1977	
	Law or regulation	Guidelines	Law or regulations	Guidelines
Alabama		X		
Alaska		NA		
Arizona		X		
Arkansas		X		
California		X	X	
Colorado		X	X	
Connecticut		NA		

TABLE XXVII.—STATES WITH MINIMUM LOSS RATIOS MANDATED BY LAW, REGULATION OR GUIDELINES—Continued

	1984		1977	
	Law or regulation	Guidelines	Law or regulations	Guidelines
Delaware	NA			
District of Columbia	X			
Florida		X		
Georgia	X			
Hawaii	X			
Idaho	NA			
Illinois				
Indiana		X		X
Iowa				X
Kansas	X			
Kentucky	X			X
Louisiana				
Maine	X			
Maryland	X			X
Massachusetts	X			
Michigan	X		X	X
Minnesota	NA		X	
Mississippi	X		X	X
Missouri				
Montana	X			
Nebraska	X			
Nevada		X		
New Hampshire	X			
New Jersey	X	X		X
New Mexico		X		
New York	X		X	X
North Carolina	X			
North Dakota	X			
Ohio	X			X
Oklahoma	X			
Oregon	X			
Pennsylvania	X		X	
Rhode Island	X			
South Carolina		X		X
South Dakota		X		
Tennessee	X			
Texas		X for M-gap		
Utah	X			
Vermont	X			X
Virginia	X			
Washington	X			
West Virginia	X	X		
Wisconsin	X			X
Wyoming	X			
American Samoa	NA		NA	
Guam	NA		NA	
Puerto Rico			NA	
Virgin Islands	NA		NA	
Total	34	10	7	12

The 1978 committee report explains the problems States have in regulating minimum loss ratios even when they do have regulations or pertinent laws in place:

> Each State was also asked what action it could take if a company exceeds minimum loss ratio requirements. The

answer for the 12 States who had loss ratio guidelines was predictable. There is little that they can do. However, surprisingly, even the eight States which had pertinent laws or regulations said they would have difficulties in enforcement. Michigan, for example, which has a 65-percent minimum ratio in regulation, was asked what action it could take if a company exceeds minimum ratios. Michigan responded, "None—unless it is determined that such inadequate rates impact upon the solvency of the insurer."

The committee questionnaire asked State commissioners to provide a list of the companies licensed to sell health insurance in their State ranked by loss ratio. They were also asked to list those companies selling Medicare supplemental insurance and rank those companies according to loss ratios. Only four States were able to provide a ranking of companies selling Medicare supplementary insurance: Arizona, Kansas, Pennsylvania, and Wisconsin. All other States responded that they did not have such information available; some said they could compile the data only with extensive allocation of time and resources—other States said they did not have the raw data, not to mention the manpower and know-how necessary to compile such a list. Some 13 States were able to provide the committee with loss ratios ranking of companies selling health insurance in general.

It should be obvious that if every insurance company in the Nation would publish this data on health insurance policies in general and Medicare supplementary policies in particular, it would be a tremendous aid to the consumer who is shopping for insurance.

4. Unit pricing.

Another progressive reform suggested by some of the States involves unit pricing of Medicare supplementary policies. Unit pricing would provide a dollar amount for each type of coverage. For example, the subscriber to a policy would be aware that it costs X amount to cover the Medicare part A deductible and Y amount for a policy or a clause which covers the part B deductible and Z amount for coverage of in-hospital coinsurance, and so forth. In this way, the policy buyer would be aware of the cost to him of each type of coverage and he would be in a position to compare coverage and cost.

It has been contended that in the area of insurance supplementary to Medicare, where policies typically cover recognized increments as described in X, Y and Z above, unit pricing could be implemented with comparative ease.

It was discovered that, while five States had unit pricing in 1977, only two States used unit pricing in 1984. In other words, today only two States require unit pricing so that consumers can do some comparison shopping with respect to their Medicare supplementary insurance (see table XXVIII).

5. Brochures on Medicare supplemental health insurance policies.

In 1984, 33 States—as compared to 18 in 1977—responded that they had pamphlets or literature addressed to senior citi-

zens to help them in their choice of Medicare supplemental health insurance policies. However, of this number, many are out of print. (See Medicare supplemental insurance article, "Consumer Reports," June 1984.)

This expression of interest on the part of these 33 States is yet another indication that the problems in the sale of Medicare supplemental health insurances policies are widespread and significant (see table XXIX).

6. Commissions.

As noted in section IV of this report, a central cause for abuses perpetrated by agents is high first-year commissions. Agents may receive anywhere from 50 to 95 percent of the first year's premium which they collect as a commission. by contrast, renewals pay the agent only 5 to 15 percent. There is, therefore a direct financial incentive on the part of the agent to sell more and more policies—to replace existing policies with new ones. Both the 1978 and 1984 questionnaires asked how many States had regulations which limited first-year commissions. In 1978, four States responded affirmatively. By 1984, only six States placed limitations on commissions (see table XXX).

REGULATION OF AGENTS

Sections III and V of the questionnaire sought to determine what requirements agents must meet before selling insurance in each State, the number of agents licensed to sell health insurance in each State, the number of complaints relating to health insurance annually by State, and disciplinary actions taken against agents and or companies when it was determined that abuses in the sale of supplemental insurance to Medicare did in fact occur. The following is an analysis of the States' response to the subcommittee's inquiry in this regard.

In 1983, Texas was the State with the most licensed insurance agents, reporting 165,592 agents, followed by Ohio with 149,001. Vermont had the fewest with 2,900. In 1977, California was the State with the most licensed insurance agents with approximately 168,000 licenses, followed by New York with 122,802. Vermont had the fewest with 1,758. The average State had 45,310 in 1983 as compared to 36,202 in 1977 (see table XXXI).

New York received the most complaints in 1983 with 61,500. The District of Columbia had the least number of complaints with 518. In 1984, the average State received 7,575 complaints, 45 percent of which or 3,163 related to the sale of health insurance (see table XXXII). In 1977, the average State received 9,641 complaints, 28 percent of which or 2,759 related to the sale of health insurance. Florida was the State with the most health insurance complaints with 14,875, and Hawaii with 69 had the fewest. In 1983, Pennsylvania had the most health insurance complaints reported with 24,928. Of those surveyed, the Virgin Islands had the fewest with 537 complaints. However, as can be noted in table XXXII, many States could not provide a breakdown.

North Carolina has revoked the most insurance licenses in the years from 1979 to 1983, with a total of approximately 6,750, fol-

lowed by New York with 1,070 and California at 606. These three States accounted for 81 percent of all licenses revoked. Several States either have not revoked a single license during the past 5 years or were not able to report it. The average among reporting States would be 305 revocations a year with respect to all kinds of insurance and 74 revocations a year related to the sale of health/accident insurance. But for the inclusion of figures from the above three States, these State averages would be reduced by over two-thirds (see table XXXIII).

By 1983, California had the most revocations for abuse in the sale of health insurance—906 over the last 5 years—followed by New York with 485 revocations. In 1977, New York had the most revocations for abuse in the sale of health insurance—305 over the previous 5 years—followed by Florida which had 191. Many States either had no revocations for health insurance violations or did not answer the question. In 1983 some 45 percent of the New York revocations related to health insurance abuses. California's figures were not broken down, thus impossible to compare. However, in 1977, 83 percent of the New York revocations related to health insurance abuses as did 75 percent of the Florida revocations.

In terms of disciplining insurance companies, in 1983 Delaware, Georgia, and Pennsylvania ranked highest, having fined or disciplined 50, 29, and 13 companies in the last 3 years respectively. In fact, only 16 States reported having fined or otherwise disciplined any insurance companies over this period. In the first survey, Kansas, Massachusetts, and Texas ranked first, having fined or disciplined 42, 25, and 20 companies in the 3-year period ending in 1977. The statistical average for both periods shows that less than one company had been fined or disciplined by the average State during each of the past 3 years. (see table XXXIV).

TABLE XXVIII.—STATES WHICH REQUIRE BY LAW OR REGULATION UNIT PRICING OF MEDICARE SUPPLEMENTAL POLICIES SO CONSUMERS CAN DO SOME COMPARISON SHOPPING

	1984		1977	
	Yes	No	Yes	No
Alabama		0		0
Alaska				
Arizona		0		0
Arkansas		0		0
California	X			0
Colorado		0		0
Connecticut		0		0
Delaware				
District of Columbia		0		
Florida		0		0
Georgia				0
Hawaii		0		0
Idaho				0
Illinois		0		0
Indiana		0		0
Iowa		0		0
Kansas		0		0
Kentucky		0		0
Louisiana		0		0
Maine		0		0
Maryland	X		X	

TABLE XXVIII.—STATES WHICH REQUIRE BY LAW OR REGULATION UNIT PRICING OF MEDICARE SUPPLEMENTAL POLICIES SO CONSUMERS CAN DO SOME COMPARISON SHOPPING—Continued

	1984		1977	
	Yes	No	Yes	No
Massachusetts				0
Michigan		0		0
Minnesota				0
Mississippi		0		0
Missouri		0		0
Montana		0		
Nebraska		0		0
Nevada		0		0
New Hampshire		0		0
New Jersey		0		0
New Mexico				0
New York		0		0
North Carolina		0		0
North Dakota		0	X	
Ohio		0		0
Oklahoma				0
Oregon		0		0
Pennsylvania		0		0
Rhode Island				0
South Carolina		0		0
South Dakota		0		0
Tennessee		0		0
Texas		0		0
Utah			X	
Vermont		0	X	
Virginia		0		0
Washington		0	X	
West Virginia		0		0
Wisconsin		0	X	
Wyoming				0
American Samoa				
Guam				
Puerto Rico		0		
Virgin Islands				
Total	2	39	6	41

TABLE XXIX.—STATES MANDATING THAT AN AGENT MUST PROVIDE THE CLIENT WITH A STATE-APPROVED CONSUMER GUIDE AT THE TIME OF SALE

	1984		1977	
	Yes	No	Yes	No
Alabama	X			0
Alaska				
Arizona	X			0
Arkansas	X	0		0
California	X		X	
Colorado	X			0
Connecticut	X			0
Delaware				0
District of Columbia	X			
Florida	X			0
Georgia				0
Hawaii	X			0
Idaho				0
Illinois	X			0

TABLE XXIX.—STATES MANDATING THAT AN AGENT MUST PROVIDE THE CLIENT WITH A STATE-APPROVED CONSUMER GUIDE AT THE TIME OF SALE—Continued

	1984		1977	
	Yes	No	Yes	No
Indiana	X			0
Iowa	X			0
Kansas	X			0
Kentucky	X			0
Louisiana	X			0
Maine				0
Maryland	X			0
Massachusetts				0
Michigan	X			0
Minnesota				0
Mississippi	X			0
Missouri	X			0
Montana	X		X	
Nebraska		0		
Nevada	X			0
New Hampshire	X			0
New Jersey	X			0
New Mexico			X	
New York		0		0
North Carolina	X			0
North Dakota	X		X	
Ohio	X			0
Oklahoma				0
Oregon		0	X	
Pennsylvania	X			0
Rhode Island				0
South Carolina	X			0
South Dakota	X			0
Tennessee	X			0
Texas	X			0
Utah				0
Vermont	X			0
Virginia	X			0
Washington	X		X	
West Virginia	X			0
Wisconsin	X		X	
Wyoming				0
American Samoa				
Guam				
Puerto Rico				
Virgin Islands				
Total	36	3	7	41

TABLE XXX.—STATES WITH REGULATIONS WHICH LIMIT THE AMOUNT OF COMMISSIONS THAT AGENTS MAY RECEIVE

	Yes	No
Alabama		0
Alaska		
Arizona		0
Arkansas		0
California	X	
Colorado		0
Connecticut		0
Delaware		
District of Columbia		0

TABLE XXX.—STATES WITH REGULATIONS WHICH LIMIT THE AMOUNT OF COMMISSIONS THAT AGENTS MAY RECEIVE—Continued

	Yes	No
Florida		0
Georgia		
Hawaii		0
Idaho		
Illinois		0
Indiana		
Iowa		0
Kansas	X	
Kentucky		0
Louisiana		0
Maine		0
Maryland		
Massachusetts		
Michigan		0
Minnesota		
Mississippi		0
Missouri		0
Montana		0
Nebraska		0
Nevada	X	
New Hampshire		0
New Jersey		0
New Mexico		
New York		0
North Carolina		0
North Dakota		0
Ohio		0
Oklahoma		
Oregon		0
Pennsylvania	X	
Rhode Island		
South Carolina		0
South Dakota	X	
Tennessee		0
Texas		0
Utah		
Vermont		0
Virginia		0
Washington		0
West Virginia		0
Wisconsin		0
Wyoming		
American Samoa		
Guam		
Puerto Rico	X	
Virgin Islands		
Total	6	33

TABLE XXXI.—HOW MANY LICENSED AGENTS DO YOU HAVE IN YOUR STATE?

	1983	1977
Alabama	30,210	NA
Alaska	NA	NA
Arizona	32,527	15,000
Arkansas	20,000	15,000
California	117,070	168,413
Colorado	26,000	25,000
Connecticut	50,000	24,000

TABLE XXXI.—HOW MANY LICENSED AGENTS DO YOU HAVE IN YOUR STATE?—Continued

	1983	1977
Delaware	9,000	NA
District of Columbia	26,000	20,000
Florida	81,449	54,314
Georgia	44,338	38,000
Hawaii	7,500	4,931
Idaho	NA	9,000
Illinois	50,000	85,000
Indiana	47,862	56,000
Iowa	28,879	35,000
Kansas	24,500	20,251
Kentucky	32,000	24,116
Louisiana	40,000	35,000
Maine	6,500	7,000
Maryland	39,012	30,000
Massachusetts	180,000	70,000
Michigan	51,167	30,000
Minnesota	NA	52,000
Mississippi	24,800	24,000
Missouri	60,000	50,000
Montana	7,268	NA
Nebraska	16,000	NA
Nevada	13,680	7,000
New Hampshire	e2,000	4,456
New Jersey	40,000	64,000
New Mexico	55,000	15,000
New York	140,550	122,802
North Carolina	68,000	50,000
North Dakota	9,400	8,000
Ohio	149,001	83,310
Oklahoma	25,000	17,861
Oregon	NA	23,842
Pennsylvania	133,745	100,000
Rhode Island	NA	NA
South Carolina	23,992	16,580
South Dakota	11,342	7,438
Tennessee	55,000	23,000
Texas	165,952	94,896
Utah	15,000	8,429
Vermont	2,900	1,758
Virginia	44,726	33,000
Washington	22,250	18,000
West Virginia	12,000	8,290
Wisconsin	40,000	26,423
Wyoming	3,000	3,000
American Samoa		
Guam		
Puerto Rico	NA	
Virgin Islands		
Total	2,084,260	1,629,110
Average	45,310	36,202

TABLE XXXII.—TOTAL COMPLAINTS RECEIVED BY STATE INSURANCE DEPARTMENTS IN 1983 AND PERCENTAGE RELATED TO THE SALE OF HEALTH INSURANCE

	Total complaints	Complaints related to accident/health insurance	Percent of accident/health complaints to total
Alabama	3,264	1,606	49
Alaska	NA	NA	NA

TABLE XXXII.—TOTAL COMPLAINTS RECEIVED BY STATE INSURANCE DEPARTMENTS IN 1983 AND PERCENTAGE RELATED TO THE SALE OF HEALTH INSURANCE—Continued

	Total complaints	Complaints related to accident/health insurance	Percent of accident/health complaints to total
Arizona	5,448	2,520	46
Arkansas	3,150	1,726	54.7
California	12,057	5,483	45.4
Colorado	4,772	2,100	44
Connecticut	6,500	2,000	30.7
Delaware	NA	NA	NA
District of Columbia	627	126	20
Florida	50,856	NA	NA
Georgia	9,800	4,960	50.6
Hawaii	NA	NA	NA
Idaho	NA	NA	NA
Illinois	12,968	5,806	44.7
Indiana	4,170	NA	NA
Iowa	5,062	3,208	63.3
Kansas	7,477	2,987	39.9
Kentucky	4,910	1,993	40.5
Louisiana	5,322	3,193	60
Maine	1,290	324	25.1
Maryland	15,080	2,927	19.4
Massachusetts	15,000	NA	NA
Michigan	6,089	NA	NA
Minnesota	NA	NA	NA
Mississippi	6,456	3,415	52.8
Missouri	7,392	3,515	47.5
Montana	1,869	1,238	66.2
Nebraska	3.030	1,615	53.3
Nevada	1,953	NA	NA
New Hampshire	1,240	277	22.3
New Jersey	3,329	NA	NA
New Mexico	e.10,000	e.5,500	55
New York	NA	e.6,000	NA
North Carolina	13,805	12,424	89.9
North Dakota	1,553	598	38.5
Ohio	6,180	4,230	68.4
Oklahoma	NA	NA	NA
Oregon	NA	NA	NA
Pennsylvania	24,948	2,747	11
Rhode Island	NA	NA	NA
South Carolina	NA	NA	NA
South Dakota	NA	NA	NA
Tennessee	4,821	2,540	52.6
Texas	20,905	14,447	69.1
Utah	1,500	750	50
Vermont	911	170	18.6
Virginia	2,849	NA	NA
Washington	5,551	2,239	40.3
West Virginia	3,437	e.1,014	29.5
Wisconsin	6,906	3,668	53.1
Wyoming	NA	NA	NA
American Samoa	NA	NA	NA
Guam	NA	NA	NA
Puerto Rico	537	215	40
Virgin Islands	NA	NA	
Total	303,014	107,561	
Average	7,575	3,163	45.2

TABLE XXXIII.—HOW MANY AGENTS HAVE HAD THEIR LICENSES REVOKED FOR ABUSES TO THE SALE OF ACCIDENT/HEALTH INSURANCE OVER EACH OF THE LAST (SIX) YEARS?

	1983	1982	1981	1980	1979	Total
Alabama	11	6	4	8	13	42
Alaska	NA	NA	NA	NA	NA	NA
Arizona	9	14	17	16	11	67
Arkansas	6	4	2	5	2	19
California	224	238	160	156	128	906
Colorado	NA	NA	NA	NA	NA	NA
Connecticut	2	0	0	1	3	6
Delaware	NA	NA	NA	NA	NA	NA
District of Columbia	0	0	0	0	0	0
Florida	44	NA	NA	NA	NA	NA
Georgia	8	13	15	10	12	58
Hawaii	0	0	0	0	0	0
Idaho	NA	NA	NA	NA	NA	NA
Illinois	NA	NA	NA	NA	NA	NA
Indiana	10	14	9	4	14	51
Iowa	9	5	7	4	3	28
Kansas	2	1	4	0	1	8
Kentucky	7	4	1	0	1	12
Louisiana	18	12	8	5	3	46
Maine	1	0	0	0	0	1
Maryland	NA	NA	NA	NA	NA	NA
Massachusetts	NA	NA	NA	NA	NA	NA
Michigan	NA	NA	NA	NA	NA	NA
Minnesota	NA	NA	NA	NA	NA	NA
Mississippi	NA	NA	NA	NA	NA	NA
Missouri	4	0	1	0	4	9
Montana	1	4	7	1	0	13
Nebraska	NA	NA	NA	NA	NA	NA
Nevada	NA	NA	NA	NA	NA	NA
New Hampshire	NA	0	0	0	0	NA
New Jersey	NA	40	NA	NA	NA	NA
New Mexico	14	12	NA	NA	NA	NA
New York	78	175	85	67	80	485
North Carolina [1]						
North Dakota	3	2	1	NA	NA	6
Ohio	NA	NA	NA	NA	NA	NA
Oklahoma	NA	NA	NA	NA	NA	NA
Oregon	20	10	18	10	23	81
Pennsylvania	3	5	0	5	1	14
Rhode Island	NA	NA	NA	NA	NA	NA
South Carolina	71	NA	NA	NA	NA	NA
South Dakota	5	10	17	8	4	44
Tennessee	e.30	e.30	e.30	e.30	e.30	e.150
Texas	56	NA	NA	NA	NA	NA
Utah	NA	NA	NA	NA	NA	NA
Vermont	0	0	0	0	1	1
Virginia	NA	NA	NA	NA	NA	NA
Washington	2	1	3	4	3	13
West Virginia	1	2	1	0	0	4
Wisconsin	17	14	17	14	18	80
Wyoming	1	1	1	1	5	10
American Samoa	NA	NA	NA	NA	NA	NA
Guam	NA	NA	NA	NA	NA	NA
Puerto Rico	NA	NA	NA	NA	NA	NA
Virgin Islands	NA	NA	NA	NA	NA	NA
Total	707	667	458	399	410	2204
Average	22	22	16	14	15	79

[1] Approximately 200 to 300.

TABLE XXXIV.—HOW MANY INSURANCE COMPANIES HAVE BEEN FINED OR OTHERWISE DISCIPLINED OVER THE PAST 3 YEARS FOR VIOLATIONS OR ABUSES WITH RESPECT TO THE SALE OF HEALTH INSURANCE?

	1984	1977
Alabama	1	NA
Alaska	NA	NA
Arizona	12	0
Arkansas	NA	0
California	NA	0
Colorado	NA	NA
Connecticut	2	NA
Delaware	e.50	NA
District of Columbia	0	NA
Florida	NA	NA
Georgia	29	NA
Hawaii	0	0
Idaho	NA	0
Illinois	7	2
Indiana	0	0
Iowa	NA	4
Kansas	NA	42
Kentucky	11	NA
Louisiana	NA	0
Maine	NA	0
Maryland	NA	2
Massachusetts	NA	25
Michigan	NA	NA
Minnesota	NA	1
Mississippi	NA	0
Missouri	0	0
Montana	8	NA
Nebraska	NA	NA
Nevada	NA	NA
New Hampshire	NA	2
New Jersey	0	0
New Mexico	NA	5
New York	8	NA
North Carolina	0	0
North Dakota	0	NA
Ohio	NA	NA
Oklahoma	NA	4
Oregon	NA	NA
Pennsylvania	13	NA
Rhode Island	0	0
South Carolina	NA	0
South Dakota	NA	0
Tennessee	10	0
Texas	7	20
Utah	6	NA
Vermont	2	0
Virginia	NA	NA
Washington	7	0
West Virginia	1	NA
Wisconsin	NA	NA
Wyoming	NA	NA
American Samoa	NA	NA
Guam	NA	NA
Puerto Rico	NA	NA
Virgin Islands	NA	NA
Total	174	107
Average	7.25	3.8

By extrapolation it is easy to see that the average State insurance department is kept very busy not only reviewing policies before they can be sold but also responding to consumer complaints, disciplining agents where necessary, and, less frequently, the companies for which they work. As noted above, the average State in 1983 will have 10 investigators and they will have the formidable task of investigating an average of 7,575 complaints, which works out to 758 complaints per investigator per year. Seven of these 10 investigators will primarily investigate health insurance complaints in the average State. They have a caseload of 3,163 complaints or about 452 complaints per investigator per year.

THE STATES' VIEWS ON FEDERAL REGULATION OF INSURANCE

Section VII of the questionnaire included three questions about Federal regulation. The first asked whether the State commissioners favored the repeal of the McCarran-Ferguson exemption to allow the full application of Federal antitrust and other laws to the insurance industry. A second question was narrower in scope, asking if the commissioners would support authorizing the Federal Trade Commission to regulate unfair trade practices in the industry. The third question was whether the commissioners would support the narrowest possible Federal intervention—authorizing the Federal Trade Commission to issue minimum standards in the limited area of Medicare supplemental policies.

Few commissioners were willing to support any kind of Federal regulation of the insurance industry. One State, North Carolina, answered they would favor repeal of McCarran-Ferguson. Two States, North Carolina and Ohio, favored giving the FTC broad authority in this area. Three States, North Carolina, Ohio, and Missouri, said they could support giving the FTC narrow authority to regulate Medigap insurance.

In its 1978 investigation, the committee found that:

> In the interviews which the staff conducted with insurance commissioners, it was learned that most States believed that Federal regulation would supplant their own and that this would be detrimental. When the staff interviewers suggested that the Federal Government may well be given concurrent jurisdiction in certain limited areas (such as Medicare supplementary insurance) where the Federal Government has caused much of the problem, the attitudes of many State commissioners softened.

VIEWS OF STATE OFFICIALS ON REGULATORY ISSUES

Many views were expressed by the State insurance commissioners in their responses to the subcommittee. Many seemed to feel that while there has been much improvement in the supplemental health insurance field, more work is still needed. Below is a sample of statements sent to the subcommittee by the State commissioners:

Arizona

"* * * The Department, together with a local television station, KPNX-TV, undertook a 'sting' operation relating to the sale of Medicare supplement insurance policies. The 'sting' involved the video taping of actual sales presentations to a 79-year

old prospective policyholder. Of the 11 agents videotaped during the sting, the Department issued notices of hearing against 10, alleging material misrepresentations in connection with their respective sales presentations. All 10 were disciplined by this agency * * *. We are a consumer oriented, enforcement minded Department that has cracked down in a major way on abuses in the sale of health insurance products to the elderly * * *"

J. MICHAEL LOW,
Director of Insurance.

New York

"* * * Your State government has an obligation to furnish seniors in New York's family with the information required to wisely select needed insurance, while rejecting duplicate and inadequate coverage. Your insurance department will continue to produce the Medicare supplement brochure as well as other consumer brochures that help New Yorkers become better informed insurance consumers."

MARIO M. CUOMO,
Governor.

Florida

"* * * With regard to whether states already have * * * adequate regulatory tools, I would point out that state laws and enforcement vary. Even with tough state laws, a regulatory agency must be adequately funded to ensure an adequate enforcement program * * *."

BILL GUNTER,
Insurance Commissioner.

Washington

"* * * The insurance climate in the state of Washington is much better for seniors than it was a few years ago, and Commissioner Marquardt is justifiably proud of his efforts to deal with this problem. However, to maintain and improve the present climate will require continued vigilance and adequate resources. Thus, the interest of your committee in this ongoing problem is most welcome."

DAVID H. ROGERS,
Chief Deputy Insurance Commissioner.

1986 SURVEY TO STATE INSURANCE COMMISSIONERS REQUESTING THEIR EXPERIENCES WITH MEDICARE SUPPLEMENTAL INSURANCE

In March 1986, the Subcommittee on Health and Long-Term Care once again sent a questionnaire to all 50 State departments of insurance. A sample of this questionnaire can be found in appendix B of this report. The purpose of the 1986 inquiry was to determine whether the States' experiences had changed significantly since the comprehensive 1984 questionnaire. At the time this report went to print, 30 States had responded to the 1986 questionnaire and telephone interviews were conducted with those States who were unable to remit the questionnaire within the subcommittee's time frame. The summary which follows is based on the percentage of States responding.

Essentially, the 1986 response mirrors the 1984 response. Little noticeable change had taken place between 1984 and 1986. The trends, in terms of increasing annual State budgets for the insurance departments, decreasing departmental staff, increasing awareness of abuses in most categories, and minimum enforcement efforts, persist.

In terms of budget and salary, the States reported a slight increase, on the average, over their 1984 budget, but a declining number of staff assigned to investigate abuses in the sale of insurance: six investigators were assigned and 1986 versus seven in 1983 on the average. Yet, the total volume of all premiums paid for all kinds of insurance in the States for 1985 had increased, leaving fewer investigators to review an increasing number of complaints.

Although the average number of licensed insurance agents increased from 1983 to 1985, the requirements for licensing and regulating agents were not toughened. The number of agents who have had their licenses revoked changed from 15 per State in 1977 to 22 in 1983. It is estimated that about 35 agents, on average, will be so disciplined in 1986.

Approximately 24,000 agents, on the average, were licensed by each State to sell health insurance in 1984. According to the subcommittee, an estimated 26,000 will be licensed to sell such insurance this year.

Again, only seven States reported mandatory review procedures covering the various aspects of health insurance, including Medigap policies, as taken from the NAIC model statute.

The minimum average loss ratio was low—62 percent for 30 States in 1986, compared to 60 percent for all States responding in 1984.

On average, the 30 States reported receiving about 9,500 complaints in 1985, up about 2,000 over 1983. Of these, about one-third related to health insurance, as compared to about 45 percent in 1984.

The average number of insurance companies fined or disciplined for abuses in the sale of health insurance to the elderly was about 7.25 percent in 1984. By 1986, that percentage had increased to about 8 percent.

With regard to abuses reported by the States, it is no surprise that the problem hasn't diminished, but has increased. The same 22 types of abuses are reported by the States to persist. "Overloading" and "the government look," now criminal offenses, occur with such regularity that the States are unanimous in their experience with such abuses.

Despite the failure of many States to make a significant impact on serious abuses, State commissioners remain adamant in their opposition to more Federal efforts in these areas.

SUMMARY

It is evident from the preceding section that the average State insurance department was kept very busy in 1984, regulating an average of over $5 billion in insurance premiums paid that year. The average department was responsible for licensing 45,310 agents. Every year, the average department must review 7,705 accident and health insurance policies before they can be offered for sale in the State. That department will receive and respond to an average to 9,641 complaints, but the average State will have only one investigator for every 758 complaints which it receives.

Given all these facts, it should be of little surprise that the average State will revoke only 22 licenses of agents each year for violations in conjunction with the sale of health insurance. The average State did not fine or discipline any insurance companies for these kinds of abuses—in fact, only 16 States have fined or formally disciplined companies in the past 8 years.

In terms of recognition of the problem of Medicare supplemental health insurance, lively scandals have erupted in a number of States and the District of Columbia. However, some 35 State com-

missioners answered that they already had the regulatory tools in place to handle the problem.

An analysis of the regulatory tools in place in the States yields quite a different conclusion. Only six States said that they could limit the amount of commissions paid to agents. Only two said they had unit pricing; seven required the use of approved graphics proceeding any sale. Only 34 States had minimum loss ratios that could be enforced. Thirty-nine States had regulations relating to readability, and 39 also regulate the size of print which may be used.

A review of the regulations enumerated in this section indicates that between 10 and 15 States have barely any regulations, or were not knowledgeable enough to answer the questions.

What is clear from this review is that, while many States have adopted the regulations recommended by the NAIC, the quality of enforcement of these regulations in the health insurance field leaves much to be desired.

VI. EFFORTS AT REGULATION OF MEDICARE SUPPLEMENTAL INSURANCE BY THE FEDERAL GOVERNMENT

The subcommittee found that there has been a general abdication of regulatory authority over supplemental Medicare insurance by the Federal Government. Despite enactment by the Congress of the landmark Baucus/Pepper Amendments of 1980, which were designed to afford senior citizens some measure of protection in the purchase of Medigap insurance, the activity of the Federal Government in enforcing and overseeing the enforcing of these safeguards has been shockingly inadequate. The two Federal agencies with primary responsibility in this area, the Department of Health and Human Services and the Federal Trade Commission, have been no more then sleeping watchdogs allowing unscrupulous insurance companies and their agents to feed upon the fears and pocketbooks of older Americans. The U.S. Department of Justice has done little to investigate and prosecute cases of Medigap abuse. Only the U.S. Postal Service, with its responsibility and limited authority to combat mail fraud, has been at all aggressive in protecting Medigap consumers. This section briefly summarizes the activities of each of these Federal agencies in the regulation of Medicare supplemental insurance.

A. Department of Health and Human Services (HHS)

The Department of Health and Human Services (HHS) is the Federal agency with primary responsibility for the implementation and administration of the Baucus/Pepper Medigap reform legislation passed by the Congress in 1980. The law, section 507 of the Social Security Disability Amendments of 1980, required the Secretary of HHS to:

(1) Establish a voluntary Federal certification program for Medicare supplemental insurance policies meeting federally prescribed minimum standards;

(2) Conduct a comprehensive study and evaluation of the comparative effectiveness of various State approaches to the regulation of Medicare supplemental insurance policies in lim-

iting marketing and agent abuse; assuring the dissemination of such information to Medicare beneficiaries as is necessary to permit informed choice: promoting policies which provide reasonable economic benefits for Medicare beneficiaries; reducing the purchase of unnecessary duplicative Medigap coverage; improving price competition; and establishing effective State regulatory programs. This study was also required to address the needs for standards or certification of health insurance policies, other than standard Medigap or service benefit policies, such as hospital and long-term care indemnity policies and dread disease policies sold to older Americans.

(3) Submit to the Congress no later than January 1, 1982, a report on the results of the above-mentioned study and evaluation, as well as recommendations as to the need for legislative and administrative changes to accomplish the objectives outlined above, including the need for mandatory Federal program to assure the marketing of appropriate types of Medigap policies and such other means the Secretary finds may be appropriate to enhance effective State regulation of such policies.

(4) Submit to the Congress no later than July 1, 1982, and at least every 2 years thereafter, a report evaluating the effectiveness of the voluntary certification process and criminal penalties established under this law. This report is also to analyze the impact of these on the types, market share, value, and cost of Medicare beneficiaries of policies receiving certification; the need for any change in the certification program to improve its administration or effectiveness; and, whether the certification program and criminal penalties should be continued.

Within HHS, the Health Care Financing Administration (HCFA) is primarily responsible for carrying forth these activities on behalf of the Secretary. The Office of the Inspector General within HHS has responsibility for the investigation of cases of Medigap abuses outlawed under Baucus/Pepper.

It was not until 1982 that HCFA issued regulations implementing the voluntary certification program as of July 1 of that year. The regulations also contained the minimum standards required of policies for this certification. The standards set forth were derived from a revised set of model standards approved by the National Association of Insurance Commissioners (NAIC). The process established by the regulations is one by which insurers could voluntarily submit their Medigap policies for review and certification by HCFA. An emblem, approved by the Secretary of HHS, would be affixed to policies receiving Federal certification. This emblem would serve as a kind of Federal "Good Housekeeping Seal of Approval" so that elderly consumers would know that the enscribed policy met certain protective standards set forth by the Federal Government.

To date, not one Medigap policy has been federally certified. Only four policies have been submitted for review.

HCFA has approved 46 States as having equal or more stringent regulatory standards than set forth under the Federal minimum standards. All Medigap policies issued in these States are thus deemed to meet the Federal minimum standards. Four States, New York, Massachusetts, Wyoming, and Rhode Island, have not had

their regulatory programs approved as meeting Federal standards. These States have not adopted the National Association of Insurance Commissioners' Model Standards.

The comprehensive evaluation of State regulation, although required by law to be delivered to the Congress by January 1, 1982, has never been fully transmitted. Although HCFA has publically stated that this report is over 4 years late because of administrative delays, the subcommittee has learned from internal HCFA sources that the report actually was completed in mid-1983. These HCFA sources told the subcommittee that pressure from representatives of the insurance industry, generated by the report's strong criticism of cancer insurance, had an influence on this delay.

Further, HCFA sources indicate that this report was updated for release in May of 1986, but has not yet been transmitted to Congress. The subcommittee has since learned that copies of this unreleased report have been offered for sale to the public—at a cost of $35—by the west coast consulting firm which conducted the study under a contract from HCFA.

The second report required by the Baucus/Pepper amendments, which was due to Congress by July 1, 1982, and at least every 2 years thereafter, was transmitted June 13, 1984 as part of "Fiscal Year 1981 Annual Report on Medicare." This report, only several pages in length, does little more than restate the requirements of the voluntary certification process. Efforts to provide Medicare beneficiaries information about Medicare were also included.

While this initial report was transmitted to the Congress 2 years later than required by law, the Congress has yet to receive any of the required follow-up reports. HCFA sources, however, indicate to the subcommittee that these reports have been completed annually since 1982, but have never been released by HCFA to the Congress.

The 1981 Annual Report on Medicare, as stated above, reviews a process for administering the new penalty provisions of the Baucus/Pepper Amendments. The report states:

> Representatives of HCFA, the Office of the Inspector General, the Department of Justice, and the Social Security Administration developed a coordinated procedure for screening, investigating, and prosecuting cases arising from the penalty provisions provided in section 1882(d) of the Social Security Act. HCFA, through its regional offices, is responsible for the preliminary screening of complaints and for providing information about complaints to the appropriate State insurance department. The Office of Inspector General is responsible for investigating cases referred by HCFA and for coordinating activities with the State insurance departments. Further OIG is serving as liaison between State insurance departments and the U.S. attorneys.

In response to a letter of inquiry from Chairman Pepper, the HHS Secretary Margaret M. Heckler on July 15, 1985, indicated that HHS has identified only 11 cases involving alleged Medigap abuses.

The majority of these cases involved insurance agents misrepresenting themselves to potential customers as representatives of Medicare or Social Security. None of these reported cases involved

the actual imposition of the penalties established under Baucus/Pepper. There were no prosecutions.

In an effort to determine the current status of HCFA activities related to the regulation of Medicare supplemental health insurance, Chairman Pepper wrote the following letter to HCFA Administrator William Roper, M.D. No response to this letter has been received as of this date.

U.S. HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON AGING,
Washington, DC, June 2, 1986.

Hon. WILLIAM ROPER,
Administrator, Health Care Financing Administration, Washington, DC.

DEAR MR. ROPER: Your assistance in a matter of great importance to the Subcommittee on Health and Long-Term Care of the House Select Committee on Aging would be most appreciated.

As a part of its continuing concern with Medicare supplemental health insurance, the Subcommittee would appreciate your response to the following questions relative to the implementation of Public Law 96-265, the Social Security Disability Amendments of 1980:

Subsection 1882(a) of the Social Security Act requires the Secretary to establish a program of voluntary certification for Medicare supplemental health insurance policies. To date, how many policies have been submitted to the Secretary for certification? How many of these policies have been certified? Please include a copy of an approved policy affixed with the secretarial certification emblem, as well as a copy of the official emblem itself.

Subsection 1882(b) of the Social Security Act states that any Medicare supplemental health insurance policy in any State which the Supplemental Health Insurance Panel determines has established under State law a regulatory program that meets certain requirements shall be deemed to meet the voluntary certification standards. How many States have been determined by the Secretary to meet these regulatory standards? What specific actions did HCFA take to determine initially whether each State's regulatory program met the specified criteria? What specific ongoing review does HCFA perform to determine States' maintenance of the regulatory programs?

Subsection 1882(f) of the act requires the Secretary to conduct a comprehensive study and evaluation of the comparative effectiveness of State approaches to the regulation of Medicare supplemental health insurance policies. It requires that the Secretary submit to the Congress no later than January 1, 1982, a report on the results of this study. This subsection also requires the Secretary to submit to the Congress no later than July 1, 1982, and at least every two years thereafter a report evaluating the effectiveness of the certification procedure and the criminal penalties established under section 1882. To date, has the Secretary submitted to the Congress these completed reports? If he has not, what progress has been made toward completion of each report? What specifically has caused these long delays?

Through 1984 HCFA maintained a "Medigap Operations" staff within its Bureau of Program Operations. What were the reasons for its dissolution? How many staff—in FTE's—has HCFA dedicated to the administration of Medigap activities in fiscal years 1981-86? How many are planned for fiscal year 1987?

I would like to ask that the subcommittee receive this information by June 16, 1986. If you or your staff have any questions concerning this request, please contact Kathy Gardner-Cravedi or Peter Reinecke of the Subcommittee Staff at (202)226-3381.

Thank you in advance for your assistance in this very important matter of mutual concern.

With kindest regards.

Very sincerely,

CLAUDE PEPPER,
Chairman.

B. Federal Trade Commission

The Federal Trade Commission (FTC) is the independent Federal agency which is charged with the oversight of activities relative to the protection against deceptive trade and sales practices in the

sale of Medicare supplemental insurance. The subcommittee found that as of 1985, the FTC stopped all ongoing investigatory activities relative to Medigap. The premise for this inactivity, according to the Commission, is a lack of jurisdiction over the sale of insurance as well as the existence of protective legislation in the form of Baucus/Pepper.

Two pieces of legislation enacted by Congress in recent times, the McCarran-Ferguson Act and the FTC Improvements Act of 1980 have limited FTC's jurisdiction over the business of insurance only to the extent that it is not regulated adequately by State law. The FTC has stated that it is of the opinion that the mere presence of State laws is generally enough to usurp its authority in insurance related matters. This has been a matter of some controversy.

The FTC Improvements Act of 1980 has been interpreted to restrict FTC ability to conduct studies and prepare reports relating to the business of insurance. Specific requests from congressional committees may be excluded from this limitation. This act in no way, however, limits the enforcement authority of the FTC that meets the restrictions of the McCarran-Ferguson Act.

The FTC's current interpretation of McCarran-Ferguson is unreasonably restrictive in looking to the existence of legislation as a measure of adequate State regulation rather than the actual enforcement of these statutes. In matters where the FTC identifies abusive practices in the sale or promotion of Medigap insurance being allowed to persist even though it may be prohibited under State law, it has the authority and duty to protect consumers and enforce Federal law. It should seek out these abusive situations aggressively.

There is also serious question about the FTC's interpretation of its authority in matters which are not clearly the business of insurance. The FTC had an ongoing investigation from 1983 to 1985 relative to interstate marketing practices and specifically the practice of lead solicitation in the marketing of Medicare supplemental insurance. According to internal FTC documents reviewed by the subcommittee, the investigation focused primarily on whether or not the interstate solicitation of prospective Medigap customers by marketing companies through the mail, which involves misrepresentation or deceptive practices, fall, under the jurisdiction of the FTC.

The Eighth Circuit Court of Appeals, applying the reasoning of the Supreme Court's decision in *FTC* v. *Travelers Health Association,* found that the FTC retains jurisdiction over an interstate insurance marketer's mail order activities whenever a State needs to "depend on any provisions, instrumentalities or processes of another State" in order to control deceptive practices within its boundaries.

The subcommittee's review of FTC documents also reveals that even the Office of General Counsel within the FTC concluded that the FTC did have authority under the law to conduct a law enforcement investigation into possible misrepresentations in the sale of mail order insurance.

Despite these facts, the FTC has chosen to end virtually all oversight and enforcement activities relative to Medigap. This is a disgrace.

C. Department of Justice

The U.S. Department of Justice has the responsibility of prosecuting cases on behalf of the Federal Government involving violations of the criminal provisions of the Baucus/Pepper Amendments of 1980. The amendments state:

> (1) Whoever knowingly or willfully makes or causes to be made or induces or seeks to induce the making of any false statement or representation of a material fact with respect to the compliance of any policy with the standards and requirements set forth in subsection (c) or in regulations promulgated pursuant to such subsection, or with respect to the use of the emblem designed by the Secretary under subsection (a), shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than 5 years, or both.
>
> (2) Whoever falsely assumes or pretends to be acting, or misrepresents in any way that he is acting, under the authority of or in association with the program of health insurance established by this title, or any Federal agency, for the purpose of selling or attempting to sell insurance, or in such pretended character demands, or obtains money, paper, documents, or anything of value, shall be guilty of a felony and upon conviction thereof shall be fined no more than $25,000 or imprisoned for not more than 5 years, or both.
>
> (3) Whoever knowingly sells a health insurance policy to an individual entitled to benefits under part A or enrolled under part B of this title, with knowledge that such individual is otherwise entitled, other than benefits to which he is entitled under a requirement of State or Federal law (other than this title), shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than 5 years, or both.

U.S. attorneys have the responsibility of actually representing the Federal Government in Medigap abuse cases. To this date, their involvement has been virtually nonexistent. Information provided the subcommittee in July 1985, indicated that the Justice Department has only been involved in three Medigap-related actions since 1981. One resulted in an indictment of insurance agents who had allegedly represented themselves as agents of the Federal Government. None of these three cases has resulted in a conviction.

The following are responses from the Justice Department to letters from Chairman Pepper inquiring as to their activities relating to Medicare supplemental insurance.

U.S. DEPARTMENT OF JUSTICE,
CRIMINAL DIVISION,
Washington, DC, May 20, 1985.

Hon. CLAUDE PEPPER,
Chairman, Subcommittee on Health and Long-Term Care, Select Committee on Aging, House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: Your letter of April 30, 1985 to the Department of Justice, in which you requested information regarding fraudulent insurance sales to the elderly under "Medigap," has been forwarded to the Criminal Division for response.

The Department of Justice maintains statistics on various violations by reference to the Federal statute involved, but it has no data regarding any specific category of victim. I would suggest that the subcommittee may wish to contact, if it has not

already done so, the Postal Inspection Service, the Federal Trade Commission and, possibly, the Department of Health and Human Services in an effort to obtain helpful information.

I regret that I am unable to be of assistance to you in this matter.

Sincerely,

STEPHEN S. TROTT,
Assistant Attorney General, Criminal Division.

U.S. DEPARTMENT OF JUSTICE,
FEDERAL BUREAU OF INVESTIGATION,
Washington, DC, June 5, 1985.

Hon. CLAUDE PEPPER,
Chairman, Subcommittee on Health and Long-Term Care, Select Committee on Aging, House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: I am writing in response to your April 30, 1985, letter requesting the details of investigations conducted by the FBI since 1981 concerning fraud in the sale of "Medigap" insurance policies.

Because of the nature of the FBI's records system, I am not able to provide the information being sought by the subcommittee. The request has been circulated among the supervisors here at FBI Headquarters responsible for the investigative program that would most likely cover such investigations, and I have been advised that they do not recall any "Medigap" matters.

Sincerely yours,

WILLIAM H. WEBSTER,
Director.

D. U.S. Postal Service

The U.S. Postal Service has the responsibility for investigating and bringing action against cases of mail and wire fraud involving the sale of Medicare supplemental health insurance. The Postal Inspection Service, within the Postal Service, is a relatively small group of 2,000 inspectors around the Nation that spends approximately 25 percent of its time combatting mail fraud, including the sale of fraudulent Medigap insurance policies to the elderly. It is currently the only Federal agency with an active ongoing effort to fight Medigap abuse.

The Postal Service inspectors have been successful in bringing literally hundreds of cases against individuals perpetrating frauds. They have uncovered and successfully brought cases ranging from business and investment frauds to health quackery, from life insurance frauds to Medigap insurance fraud, many of which are perpetrated against older Americans.

The Postal Inspection Service has had a long history of involvement in pursuing the perpetrators of fraudulent Medigap insurance sales through the mails. In response to a May 1986 letter from Chairman Pepper, the Postal Service gave reference to a number of significant insurance fraud cases it has successfully handled. Among these are the following:

> Seven individuals representing an insurance company devised a mail fraud scheme whereby between January 1977 and September 1983 they would sell worthless Medicare supplement policies to elderly Massachusetts consumers. They would falsify health histories, misrepresent insurance products and overcharge the elderly. They would exchange names of elderly customers who were "easy sales," alternated their visits to the homes of those customers and split money earned on sales made. Each policy sold contained a "preexisting condition

clause," which required the passage of a period of time ranging from 6 months to 2 years before the policyholders would be covered for ailments existing at the time of sale.

By continually replacing their insurance with new coverage, the elderly customers agents forced to begin anew to satisfy this requirement. In effect, the repeated sales caused these customers to remain uninsured. The salesmen were benefited on these sales by earning new sales commissions, which were substantially higher than renewal commissions.

The Postal Inspection Service is continuing an investigation in which 30 elderly Illinois residents were bilked out of more than $100,000 in an insurance scam conducted from March-July of 1984. The victims, aged 51 to 88, are living in communities located from the western suburbs of Chicago to south of Springfield and east to the Indiana border. Two of the victims, aged 88 and 80, are deceased.

The victims thought they were paying for either health insurance, supplemental Medicare insurance, or insurance investment plans. In several cases, the victims were told by an insurance salesman that their insurance companies were on the verge of bankruptcy and merging with companies he represented. He told his victims that the only way they could keep their present insurance was by paying him premiums and changing their policies to the new companies. The four suspects in the case actually sold nonexistent life insurance policies.

A State grand jury in Colorado recently indicted two of the same four suspects in connection with an insurance scam in which an estimated 100 elderly Denver area residents were bilked of more than $200,000 in early 1984. The indictments accuse them of "actively trading information among themselves" about elderly people who could be solicited to purchase supplemental Medicare insurance. Arrest warrants have been issued for the individuals, charging them with theft from the elderly.

Beginning in 1971 and continuing until 1980, agents representing large insurance companies used several fraudulent sales techniques ranging from being kind to lonely women to exerting pressure on their victims to force them into buying a policy to preying on the fears of losing all of their possessions as a result of a lengthy illness. A common ploy was to sell several Medicare supplement policies to the same elderly person when only one was needed to cover the various Medicare deductibles and coinsurance provisions. In order to keep the elderly victims and their families from finding out about the frauds, the insurance agents forged signatures, failed to deliver policies, and had the victims make out premium checks to various entities so they and their families would not realize the huge amount of money going to the one agency. On the 11th day of the trial in Massachusetts, the defendants pled guilty. During the aforementioned trial, a large number of elderly victims testified. Although rarely permitted in a criminal trial because of the age or physical condition of some of the victims, the testimony of 12 of the elderly witnessess was videotaped at

locations near their homes prior to trial. The videotapes were played for the jury on a specially adjusted large screen color TV during the trial. The oldest witness was 95 years old. Most were elderly women who lived alone. They were generally well-educated, with varied occupations before they retired including teachers, nurses, and a college professor.

The Postal Inspection Service, as stated above, enforces the Federal mail fraud statute which has been in existence for more than 100 years. The statute, title 18 of the United States Code, section 1341, states basically that anyone using the mails for purposes of perpetrating fraud is committing a Federal crime, which is punishable by 5 years in jail and/or a $1,000 fine—a criminal statute. The Inspection Service also enforces a civil statute—section 3005 of title 39 of the United States Code. This provision relates to false representations made through the mails. The Inspection Service can therefore move against potential fraud either civilly or criminally. Its enforcement efforts, however, are hampered by weaknesses of these two Federal statutes.

As Chairman Pepper said on the House floor in 1982:

> It is amazing to me that the Postal Service has been able to accomplish as much as it has, given these limitations. The irony is compounded by the fact that the Chief Postal Inspector of the U.S. Postal Service is the prototype for the Inspectors General that we have now established in every other Government department and yet we have failed to give the Inspection Service even the scintilla of powers we have given to all the other Inspectors General.

A criminal investigation must be conducted under the aegis of the U.S. attorney's office, which must be convinced that there is a case and that the case is of such a magnitude that prosecution will be undertaken. As then Senator Frank Moss testified before the House Post Office Committee on May 20, 1982, it is an unhappy fact that only the largest of fraud schemes ever reach the level where they are considered important enough to be taken on by most U.S. attorneys. However, it is only after convincing a U.S. attorney's office that a case meets this criterion that the Inspection Service can proceed. In the words of Senator Moss:

> The Inspection Service is in a catch 22 situation. They can only proceed if they convince a U.S. attorney that they have a case and they can only establish that they have a case if they do an investigation, which of course is not possible until they convince a U.S. attorney to let them do so.

Under the civil statute, section 3005, the Inspection Service must build a strong enough case to convince an administrative law judge after formal hearings that there are false representations made with respect to one or more products sold through the mail.

Before 1984, even if the Postal Service was successful in building a false representation case before an administrative law judge, all that happened was that a stop order was issued which barred the person who placed the ad from receiving mail in response to that ad. The mail addressed to this individual was returned to the sender. The con men who make mail fraud their profession simply

changed names or locations and continued the same schemes. In some cases they did not even do this—they flaunted the postal stop orders, forsaking the mails in favor of telephone "800" toll-free numbers which they used to market the identical products which had been enjoined, often using the identical advertisement.

In 1984, legislation was passed strengthening this civil statute and closing many loopholes so that misrepresentations of products and services were more readily policeable. The Postal Service has already put this improvement into use with inspectors around the Nation opening and closing many misrepresentation cases under its provisions. This strengthening has thus been a great assistance to these law enforcement officials in their efforts to protect the American public from unscrupulous marketers.

Unfortunately, the Federal mail fraud statute, title 18, section 1341 of the United States Code, has not been strengthened. There are also no provisions in this statute which allow the Postal Inspection Service or the FBI to force a person convicted of mail fraud to forfeit his or her interest in any property gained from the offenses of which they are convicted or their interest in property used in committing those offenses. In order to enhance Federal enforcement efforts to combat abuses in the sale of Medigap policies through the mails, many have suggested a strengthening of mail fraud penalties, as well as a forfeiture provision. These are discussed in greater depth in section VIII of this report.

VII. SUMMARY AND CONCLUSIONS

It has been almost 8 years since the release of a landmark report by the House Select Committee on Aging which documented for the first time the broad scope of abuses in the sale of insurance to supplement Medicare. It has been more than 6 years since the passage of reform legislation designed to diminish the incidence of such abuse. The purpose of this report was to determine whether abuses persist, and what impact, if any, the reform legislation has had in curbing the abuses we uncovered in 1978.

The findings of this report come in a time when the Congress and the administration are looking for ways to remedy the anticipated solvency problems facing the Medicare Program and to improve the protection its seniors receive. As we look for the means of protecting Americans against bankrupting health catastrophes like Alzheimer's disease and many forms of cancer—not covered by public or private insurance—we must scrutinize the adequacy and effectiveness of health insurance currently available to our Nation's senior citizens.

The Medicare Program has been a rich blessing for seniors and literally no one would suggest that we give it up. But the dramatic increase in the cost of health care—almost 3,600 percent since Medicare's enactment in 1965—has ripped giant holes in the fixed incomes of older Americans. Many of these people experience great difficulty trying to meet rising health care costs. Escalating costs have resulted in older Americans paying more of their incomes for doctors, hospitals, drugs, and long-term care than they did before Medicare was created in 1965.

Coupled with the aged American's increasing health care bill are costs associated with numerous costly services, like dental, eye and hearing care, out-of-hospital prescription drugs, custodial nursing and home care, and foot care, which are not covered by the Medicare Program or most private insurance.

For the many older Americans who will do anything rather than go on welfare, the purchase of health insurance supplementary to Medicare seems to be the only answer. It is wisdom which leads 21 million elderly today to buy one comprehensive policy, but it is fear that motivates many of them to buy more. The subcommittee found that the potential benefit from Medigap coverage has declined substantially since 1981, due largely to the imposition of the Medicare prospective payment system which has resulted in shorter hospital stays. Under the new system, older Americans are sent home sooner and for the most part Medigap policies stop paying when one leaves the hospital.

Unfortunately, seniors have, for the most part, a misunderstanding of Medicare and of Medicare supplemental insurance, and the extent of either one's coverage. They don't realize that if they buy more than one policy to supplement Medicare, only one will probably pay. (Policies contain a clause, generally, that states that only one policy will cover the claim.) On the other hand, nearly 90 percent of the 9,000 seniors surveyed by the subcommittee felt that Medicare or their supplemental policy would pay for custodial nursing care if required. The fact of the matter is that they don't, and what they do cover—hospital care—is a diminishing benefit, as mentioned above.

The simple fact is that no policy covers all of Medicare's gaps. Our 1986 study also confirmed the finding that few seniors understand that reality either.

The subcommittee found that seniors continue to fear the loss of independence and the onset of bankruptcy should an illness strike. If anything, their fear is heightened today due to increased awareness regarding rising medical costs. Absent aggressive regulatory and enforcement action, they remain as vulnerable today as they were in 1978 to exploitation in their search for health security.

Abuses persist in an unprecedented fashion when it comes to the sale of insurance in supplementation of Medicare. The abuses are not isolated but occur nationwide. The only difference between 1978 and today is the amount of money seniors waste for insurance ripoffs. In 1978, the subcommittee found that $1 out of every $4 spend for Medigap insurance by the elderly is wasted. Today, $3 billion is wasted annually by older Americans.

The subcommittee found that there were few problems presented by the insurance held under Blue Cross or the reputable commercial companies doing group business—which account for about $7.8 billion of the $13 billion to be spent by older Americans in 1986 on Medigap insurance. The problem remains with the $5.2 billion in Medigap policies purchased on an individual basis. The fact is that elderly will get back only about 60 percent of the money they invest in such policies in the form of claims. Adding back a factor for duplication and low loss ratios experienced in some dread disease and indemnity policies, which are not required to meet the 60 percent loss ratio requirements the majority of States have adopt-

ed, the subcommittee estimated that senior citizens are being taken for $3 billion a year and that, absent corrective action, this figure is unlikely to decrease.

The subcommittee found that even though the States have done a good job in implementing regulatory improvements in the Medigap insurance marketplace, they have been relatively ineffective in curbing abuses. A review of the new regulations since the 1978 investigation reveals that most States do not possess the necessary enforcement authority to require compliance.

To say that Federal agencies with enforcement and regulatory authority over the sale of health insurance have done a poor job since 1978 would be an understatement about their performance. The Department of Health and Human Services, for example, is responsible for implementing and overseeing the voluntary certification program and criminal penalties established by the Baucus-Pepper legislation passed in 1980. They were required to transmit to the Congress two major reports of State approaches to regulating Medigap insurance. In addition, they were required to report on the effectivenss of the voluntary certification program and criminal penalties established by the 1980 law. The Department, to date, has failed to comply with either requirement. In addition, the Department of HHS has identified only four cases involving alleged violations of these criminal provisions and have not taken formal action on any. Not one Medigap policy, to date, has been federally certified. Four have been submitted for review.

The Federal Trade Commission is responsible for the oversight of activities relating to the protection of Americans against deceptive trade and sales practices in the Medigap marketplace. Although FTC's authority is somewhat limited under Federal law, the subcommittee found that the FTC has stopped ongoing consumer protection relating to Medigap insurance.

The Department of Justice has responsibility for prosecuting cases on behalf of the Federal Government involving violations of the criminal provisions of the 1980 reform legislation. To this date, their involvement has been virtually nonexistent. Since 1981, the Department has been involved in three Medigap-related actions. One resulted in an indictment. None has resulted in a conviction. The Inspector General of the Department of Health and Human Services shares investigative activities similar to the Department of Justice in this regard. Similarly, the IG has been inactive in this area.

The U.S. Postal Service has responsibility for investigating and bringing actions against those found in violation of the wire or mail fraud statutes involving the sale of Medigap insurance. Although limited in its authority, it is currently the only agency which has made an active, ongoing effort, since 1980, to combat abuses in the sale of Medigap insurance. They have had great success in assisting the States in uncovering and prosecuting insurance scams around the country.

The subcommittee concludes that the 1980 reform legislation and State regulatory improvement in the last 6 years have been of little value because they are not enforced. The States and the Federal Government are not doing an adequate job of protecting senior citizens against unscrupulous agents who would seek to take ad-

vantage of them. This fact is particularly serious in view of the near unanimous conclusion from the States that abuses persist. The elderly today are no better off than they were in 1978. They are still seeking to purchase hope, health and security and are left with empty pockets and further disillusionment. That these practices have gone unchecked for the past 8 years is a national scandal of only slightly lesser magnitude than the schemes of the agents who perpetrate the insurance abuse.

VIII. POLICY RECOMMENDATIONS

It has been almost 8 years since the House Select Committee on Aging made a number of legislative and regulatory recommendations toward remedying abuses identified in the sale of Medicare supplemental insurance to the elderly. Unfortunately, very little meaningful progress has been made at the Federal level. Progress has been made at the State level, but much still remains to be done to provide older Americans the protection they need and deserve.

As this report documents, abuses in the sale of insurance in supplementation of Medicare persist. Furthermore, confusion is rampant among the elderly over what Medicare pays and how they can best protect themselves against its gaps. Most of what the Federal agencies have done to protect senior citizens from confusion and abuse over Medigap insurance can be characterized as bumbling and ineffective at best. There has essentially been an abdication of Federal regulatory responsibility.

Congress placed great faith in the ability of the Department of Health and Human Services and the Federal Trade Commission to work vigorously toward ensuring older Americans the protection required to end the widespread abuse identified by the Committee in the late 1970's.

DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS)

The Department of Health and Human Services, acting principally through the Health Care Financing Administration [HCFA], has been woefully remiss in its implementation and administration of the Baucus/Pepper Medigap reform legislation enacted by Congress in 1980. It must immediately take a number of steps to adequately execute its duties.

Recommendation: HHS should immediately transmit to the Congress the report of the comprehensive study and evaluation of State approaches to the regulation of Medigap. This report under the mandate of Federal law was to be delivered January 1, 1982.

Recommendation: HHS should immediately transmit to the Congress all due back reports on the effectiveness of the voluntary certification system and penalties provisions established in 1980 under Baucus/Pepper.

Recommendation: HHS should, on an annual basis, rigorously review the regulatory programs of all States to ascertain their relation to the Federal minimum standards.

Recommendation: HHS should, rigorously pursue reported cases of Medigap abuse and pursue the criminal penalties established under Baucus/Pepper against the perpetrators of Medigap abuse.

The Office of the Inspector General within HHS should undertake proactive efforts in this regard.

FEDERAL TRADE COMMISSION [FTC]

Although the FTC outlined an ambitious program in 1978, this Federal agency has ended any substantive involvement in protecting older Americans from deceptive practices in the sale and marketing of Medigap insurance.

Recommendation: The FTC must aggressively seek out and investigate Medigap abuses allowed to persist even in the presence of State law. It is especially important for the FTC to assert its authority under the law to protect consumers in the interstate sale and marketing of Medigap.

U.S. DEPARTMENT OF JUSTICE

The Department of Justice has not been aggressive in working to combat Medigap abuse.

Recommendation: The Justice Department, through U.S. attorneys around the Nation, must vigorously seek out and prosecute perpetrators of the abuse acts outlawed in the Baucus/Pepper Amendments.

U.S. POSTAL SERVICE

The U.S. Postal Service, through its Postal Inspection Service, is the only Federal agency which has effectively pursued fraud and abuse in the sale of Medigap insurance. It is ironic that this agency, with very limited association with Medigap regulation, has been able to crack down on those who use the mails to deceive the elderly, while the agencies with primary responsibility have done little.

Recommendation: Congress should consider legislation similar to H.R. 4213, which would stiffen the penalties for violations of the mail and wire fraud statutes to $10,000 fines per offense and jail sentences of up to 10 years. The Federal Government should also be given the authority to recoup moneys and other assets garnered through these abusive and deceptive acts.

THE STATES

In the past decade, while little progress has been demonstrated by the Federal Government, we have been pleased to note that useful activity has taken place at the State level. In States where vigorous leadership and enlightened legislative and political support exists, many significant improvements have been made. Even in States which have not been as active, enactment of model standards put forth by the National Association of Insurance Commissioners has had positive effects.

Unfortunately, as our surveys and investigations have demonstrated, the gap remains wide between State legislation and State regulation and enforcement. Furthermore, the educational efforts put forth by States, while commendable, have not borne the results intended. More importantly, several significant areas of abuse are generally not covered under State laws. In addition, many States

do not impose adequate standards on indemnity and dread disease Medigap insurance policies.

Recommendation: All States should require mandatory loss ratios of not less than 60 percent for hospital and long-term care indemnity policies and dread disease policies.

Recommendation: Each State insurance commissioner should collect and make available to the public a complete listing of loss ratios for each insurance company and each Medigap policy in force in the State.

Recommendation: Each State should establish minimum education, training and moral fitness requirements for insurance agents. States should consider requiring agents to post a bond or enacting legislation making an insurance agent a fiduciary with a duty to sell only the insurance suited to each individual's needs. A fiduciary duty could be imposed on agents and combined with a self-enforcing mechanism such as voidability at the buyer's option and a private right of action.

Recommendation: States should seek to regulate the amount of commissions paid to agents. Attempts could be made to equalize commissions for new policies and more renewals. The present gap between 65 percent commissions for new policies and 10 percent on renewals is unacceptable. The payment of commissions in excess of 100 percent of the first year's premium are unconscionable and should be prohibited. Any commission over 50 percent of annual premiums charges should be deemed excessive.

Recommendation: States should establish counseling offices or toll-free hotlines to aid senior citizens with questions about their insurance needs.

Recommendation: States could increase the number of investigators and auditors in their State departments of insurance and equip them with the requisite computer capability to: (a) respond to consumer complaints; (b) initiate periodic investigations into the practice of various companies and/or their agents; (c) determine if data filed with the department of insurance is accurate; (d) evaluate requests for premium increases; (e) conduct financial audits of the resources, assets and practices of insurance companies on a periodic basis; (f) identify fraud, misrepresentation or other deceptive practices in the field of insurance.

Recommendation: States should require that every company that sells insurance in the State supply the name and address of the policyholder, the kind of policy coverage and the dollar amount of premiums to the State insurance commission in a form compatible with computer facilities in the possession of the State department of insurance, to facilitate a computer analysis for duplicate billings and overlapping coverage.

THE CONGRESS

There are many possible temporary or patchwork responses to the many problems posed by Medicare supplemental insurance identified in this report. While these proposals would improve the protection against abuse and deception afforded older Americans, none get at the root cause of these problems—the inadequacy of the Medicare benefit and payment structure. There is a pressing

need for comprehensive Medicare reform to provide for full coverage of Medicare's gaps. This is the only way to truly solve the Medigap crisis we face today.

Recommendation: The Congress should consider legislation—such as H.R. 4287—to establish a new part C of Medicare which would eliminate Medicare's major gaps. This new voluntary part C would eliminate all current copayments and deductibles for parts A and B of Medicare. It should also provide coverage for vital preventive services such as eye care, dental care, hearing care and preventive physician visits. A third fundamental component of such a new part C should be comprehensive long-term care coverage for chronically ill Medicare beneficiaries. This coverage should be geared toward the environment of least restriction. This new voluntary part C program would rely on a public/private partnership, taking the best of efficiencies and innovations for private enterprise and the best from the Federal Government in safeguarding the quality and level of services provided beneficiaries.

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APPENDIX A

U.S. House of Representatives

SELECT COMMITTEE ON AGING
SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE
718 House Office Building Annex 1
Washington, D.C. 20515
(202) 226-3381

QUESTIONNAIRE ON REGULATION OF HEALTH AND MEDICARE SUPPLEMENTAL POLICIES

I. BUDGET AND RESOURCES

1. What is the budget for your office this year?_____

   What was it in 1983?_____

2. What is the total number of full-time equivalents employed by your office? _____

   How many clerical?_____ How many professionals?_____

3. Of the above number, how many professionals make up your investigative staff? _____ How many investigators do you presently have assigned to health insurance complaints? _____

4. What is the total dollar volume of all premiums paid for all kinds of insurance in your State for 1983 or most recent year?_____

5. What is the salary for the State Insurance Commissioner? _____ per year

6. Do you have on your staff a certified actuary (member of the American Academy of Actuaries)? ___Yes ___No

   What, if any, other resources do you have available to assist you in this regard?

II. POWER AND DUTIES

1. What are the basic powers and duties of your State Commission on Insurance and its Commissioner? _____

   _____

   _____

   (Will you please send me a copy of your state statute together with any summary thereof which you may have?)

2. There has been a great deal of publicity of late concerning abuses and high pressure tactics in the sale of Medicare supplemental policies to the elderly. Blame has been placed squarely on the State Insurance Commissioners. One industry spokesman recently said, "states already have regulatory tools in place that are adequate to address marketing abuses." Do you agree? ___Yes ___No

3. Do you have authority to disapprove insurance forms if premiums are deemed excessive, inadequate or unfairly discriminatory? ___Yes ___No

4. How many accident/health insurance policies or changes in existing policies did your office review in 1983? _____ in 1982? _____ in 1981? _____

5. How many of these policies (or changes) did you approve in 1983? _____ in 1982? _____ in 1981 _____?

III. AGENTS

1. What requirements must an individual meet before he or she can sell health insurance in your State? Is a license required? ___Yes ___No

   Minimum education requirements ___Yes ___No

   Prior experience ___Yes ___No

   Pass exam ___Yes ___No

   Good moral character ___Yes ___No

   If your office does not license agents, which office does?

   _____

2. How many licensed agents do you have in your State?

3. How many are licensed to sell health/accident insurance?

4. How many agents have had their licenses revoked for abuses related to the sale of accident/health insurance over each of the last five years?
   Total_____1979_____1980_____1981_____1982_____1983_____

5. How many of this total number were reinstated and later allowed to sell insurance in your state?_____

6. How many agents selling life and other kinds (except health) of insurance have had their licenses revoked in your state for any reason during the period 1979-1983?_____

7. We have heard of some cases where agents were paid more than 100 percent of annual premiums in commission. Do you have regulations which limit the amount of commissions that agents may receive?___Yes___No

   If so, what is the substance of the regulation?_____

   _____

   _____

8. In addition to delicensure, what other penalties or sanctions (civil or criminal) can be used with respect to salesmen who engage in illegal or unethical practices?

   _____

   _____

9. Suppose a senior citizen registers a complaint against a particular agent or company. What are the steps in your complaint investigation process?

   _____

   _____

IV. REGULATIONS

1. Has your office issued regulations covering the following aspects of health insurance policies in general (and Medicare supplemental policies in particular) as taken from the NAIC Model bill:

		NO	YES
a.	Terms of renewability	_____	_____
b.	Initial and subsequent conditions of eligibility	_____	_____

		NO	YES
c.	Non-duplication of coverage provisions		
d.	Readability (clear language instead of legalese)		
e.	Size of print		
f.	Pre-existing conditions		
g.	Termination of insurance		
h.	Probation periods		
i.	Limitations		
j.	Exceptions		
k.	Reductions		
l.	Eliminations		
m.	Requirements for replacements		
n.	Recurrent conditions		
o.	The definitions of such key terms as: hospital, accident, injury, physician, accidental means, total disability, nervous disorder, guaranteed renewable and non-cancellable		
p.	Require that the prospective purchase be given a form showing coverage available under Medicare and Medicaid and how the policy would fill the gaps		
q.	Cancellation of entire policy groups		
r.	Minimum coverage requirements		
s.	Limits on exclusions of pre-existing conditions		
t.	Disclosure requirements		
u.	Refund requirement		
v.	Statement of major benefit gaps in Medicare Parts A and B, with a parallel description of supplemental benefits.		

2. Do you have regulations relating to the use of pre-existing condition clauses in Medicare supplemental policies? ___Yes ___No

If yes, do these regulations
- ___a) eliminate pre-existing conditions clauses
- ___b) shorten the precondition period to 2 years
- ___c) shorten the period to 12-23 months
- ___d) shorten the period to 6 months
- ___e) require that language relating to pre-existing conditions to be printed prominently on the application form
- ___f) apply only to policies sold by mail

3. Do you have regulations relating to permissible (as opposed to deceptive) advertising of health/accident policies?___Yes___No

4. Do you have mandatory review procedures for advertisements which relate to insurance policies sold by mail?___Yes___No

5. Does your State have minimum loss ratios for various classes of health insurance policies?___Yes___No Are they mandated by law___ regulation___, or in guidelines___?

   What is your minimum loss ratio for Medicare supplemental supplemental policies? _____

   What action can you take if a company exceeds minimum ratios? _____

   _____

   _____

   _____

6. Does your State have regulations relating to minimum policy provisions in individual health/disability contracts?___Yes___No

7. Does your State have a law or regulation which requires unit pricing of Medicare supplemental policies so consumers can do some comparison shopping?___Yes___No

8. Does your State mandate that an agent must provide the client with a state-approved consumer guide at the time of sale?___Yes___No

9. Does your State mandate a no-loss right of cancellation clause to Medicare supplemental policies?___Yes___No

V. PERFORMANCE BY INSURANCE COMPANIES

1. Please complete the following table showing all companies selling health insurance in your State in 1983 (or most recent year), ranked according to loss ratios. Companies paying the highest percentage of claims from premiums should be ranked first. Please supply as much data as you can. Use table on page 5 for all health insurance companies. Use table on page 5A for only those companies selling Medigap policies.

(SAMPLE)

STATE OF ALABAMA - 1983

Name of Insurance Company	Rank	% of Market	$Amount of Premiums	Loss Ratio	Paid in Claims	Commissions	Other Administrative Costs
ABC Insurance Company	1	7	$1 million	70%	$700,000	$200,000	$100,000

COMPANIES SELLING HEALTH & ACCIDENT INSURANCE RANKED BY LOSS RATIO

STATE OF _____ YEAR _____

NAME OF INSURANCE COMPANY	RANK	PERCENT OF MARKET	DOLLAR AMOUNTS OF PREMIUMS WRITTEN	LOSS RATIOS	AMOUNT PAID ON CLAIMS	COMMISSIONS TO AGENTS	OTHER ADMINISTRATIVE COSTS
		TOTAL	TOTAL		TOTAL	TOTAL	TOTAL

COMPANIES SELLING MEDI-GAP INSURANCE RANKED BY LOSS RATIO

STATE OF _____ YEAR _____

NAME OF INSURANCE COMPANY	RANK	PERCENT OF MARKET	DOLLAR AMOUNTS OF PREMIUMS WRITTEN	LOSS RATIOS	AMOUNT PAID ON CLAIMS	COMMISSIONS TO AGENTS	OTHER ADMINISTRATIVE COSTS
		TOTAL	TOTAL		TOTAL	TOTAL	TOTAL

2. How many complaints has your office received in 1983?_____

and in 1982?_____

3. How many of these complaints relate to accident/health insurance?_____1983

_____1982

4. Will you please fill out the enclosed table relating to complaints? Supply most recent data.

(SAMPLE)

STATE OF ALABAMA

Name of Insurance Company	Rank 1983	Number of Accident and Health Complaints 1982	Accident & Health Premiums Earned 1983	Number of Complaints per $100,000 of Earned Premium	Companies' Complaints Compared to State Average
ABC Insurance Company	4	61	$500,000	12.7	3290%

(Table on page 7)

5. How many insurance companies have been fined or otherwise disciplined over the past three years for violations or abuses with respect to the sale of health insurance? _____ Please supply names and disposition of cases.

6. Has your office ever conducted a detailed financial audit of an insurance company or companies in an effort to discern if information presented to the Commission is accurate? ___Yes ___No

If yes, of what companies, when? What were the results?

ACCIDENT AND HEALTH INSURANCE: SUMMARY OF COMPLAINTS

STATE OF _____

TOP ____ Companies with more than $50,000 in earned premiums

Name of Insurance Company	Rank 1983	Number of Accident and Health Complaints 1982	Accident & Health Premiums Earned 1983	Number of Complaints per $100,000 of Earned Premium	Companies' Complaints Compared to State Average

(187)

62-241 O—86——7

— VI. ABUSES

Spokesmen for the U.S. Postal Service, the Federal Trade Commission, consumers and several insurance commissioners have indicated that there are widespread abuses by elderly. These abuses are allegedly so prevalent that they have spawned their own vocabulary. This section of this questionn ire is to ask if you have ever received complaints of any of the following practices:

	NO	YES
1. **"Wolf in sheep's clothing"** - the agent fails on initial contacts with clients to disclose that he represents a for-profit insurance company. He may say he is from Medicare and wants to help seniors with any problem they may have.		
2. **"Overselling"** - the agent sells the clients more coverage than they need or can pay for or both (e.g. loss of employment capability for a retired individual)		
3. **"More is better"** - the agent represents that his policy which has a higher premium thanthe competition is better simply because of higher premium.		
4. **"Duplicate sales"** - the agent sells the client additional policies which in effect client.		
5. **"Group policy"** - the agent represents the policy as a group policy with the implication that premiums are less when in fact there is no group and the policy is the same in coverage and premium as a regular policy.		
6. **"Clean sheeting"** - (or failure to report material condition") - the agent fails to report preexisting health conditions of clients to company, ultimately leading to a pre-existing condition disqualification of coverage when claims are filed.		
7. **"Just dropped by"** - the salesman claims to stop by the client's home to collect premiums, but actually solicits new business.		
8. **"I work with . . ."** - the licensed salesman allows an unlicensed person to front for him.		
9. **"Pie in the sky"** - (or "fine print") - the agent misrepresents policy content with words like "no waiting periods," "this policy will pay for everything," etc.		
10. **"Forgery"** - the agent either signs someone's name to the insurance forms or encourage the elderly client to illegally sign name of insured loved one.		
11. **"The Switch"** - the agent sells the client one policy but then switches and provides another for signature at time of closing.		
12. **"The add on"** - the agent, after selling one policy includes in the "forms for signature" by the client a second or third policy stating when asked, ". . . you'll need this too."		

	NO	YES
13. **"Low weekly rates"** - the agent quotes premium prices on a weekly basis but closes and sells on an annual basis.		
14. **"New is better"** - ("Twisting" or "existing policies are garbage") - the agent encourages the client to cancel perfectly good existing policies to sell a new policy which results in additional commission fees.		
15. **"The stall"** - the agent delays in responding to requests by newly insured to discuss cancellation of policy. Time limits for cancellation are thereby exceeded.		
16. **"Scare tactics"** - the agent employs scare language in closing the sale like "buy now because you may not be able to be insured later," etc.		
17. **"Corporate twisting"** - a conspiratorial arrangement whereby two or three companies transfer aged customers between themselves. This results in the expiration of policies which are in force, in favor of newly acquired policies with waiting periods.		
18. **"The government look"** - agents and/or companies use advertising materials that tend to associate them with the federal Medicare or Social Security program.		
19. **"The fence post policies"** - the agent completes applications in the name of relatives or others, unknown to the victims. This is done to bypass underwriting rules when it is know the victims already have the maximum coverage in effect with a company.		
20. **"Make the check out to me"** - the agent asks that the client make the check out to him. The agent then cashes the check, and does not report the transaction to the insurance company. No policy issued.		
21. **"The Medi-gap bandwagon"** - the agent sells the client additional accident or life insurance as if it were part of a "comprehensive Medi-gap plan."		
22. **"Postdating application"** - agent postdates application to avoid maximum coverage guidelines. Net result is that client is often not covered for initially agreed period.		

23. Others (Please specify)

(189)

24. Others (Please specify)

25. Others (Please specify)

VII. INCREASED FEDERAL REGULATION?

1. Would you favor any of the following options increasing the role of Federal regulation in insurance?

   a. Repeal of the McCarran-Fergusson exemption allowing the application of anti-trust laws to the insurance industry? ___No ___Yes

   b. Authorizing the Federal Trade Commission to regulate unfair trade practices and restraint of trade in the industry? ___No ___Yes

   c. Authorizing the Federal Trade Commission to issue minimum standards in the limited area of Medicare supplemental policies? ___No ___Yes

2. An industry spokesman has been quoted as saying that Medicare supplemental policies represent the number one problem currently confronting the State Insurance Commissioners at the present time. Do you agree? ___No ___Yes

   If no, what is your biggest problem at present? _____

   _____

   _____

VIII. REQUEST FOR FURTHER INFORMATION

1. Will you please provide the Committee with three case histories of complaints with respect to Medicare supplemental policies that were resolved by your office? Please feel free to delete names of individuals or agents if you would so desire.

2. Has your state produced any pamphlets or literature addressed to senior citizens providing guidance with respect to Medicare supplemental policies? ___No ___Yes

3. May we have a copy of your latest annual report?

4. Please send in a copy of your resume (and that of your predecessor, if available) in order to aid in our poll of the background and qualifications of State Commissioners.

OUR SINCERE THANKS FOR YOUR HELP

Would you like to testify before the House Select Committee on Aging? ___Yes ___No

Please return this questionnaire, along with additional requested information, no later than February 1, 1983 to:

Select Committee on Aging
Subcommittee on Health and Long-Term Care
Room 715, House Annex #1
Washington, D.C. 20515

APPENDIX B

U.S. House of Representatives

SELECT COMMITTEE ON AGING

SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE

377 House Office Building Annex 2

Washington, DC 20515

QUESTIONNAIRE ON REGULATION OF HEALTH AND MEDICARE SUPPLEMENTAL POLICIES
(ABBREVIATED VERSION
MARCH 1986)

1. What is the budget for your office this year? _____ What was it in 1985? _____

2. What is the total number of full-time equivalents employed by your office? _____ How many clerical? _____ How many professionals? _____

3. Of the above number, how many professionals make up your investigative staff? _____ How many investigators do you presently have assigned to health insurance complaints? _____

4. What is the total dollar volume of all premiums paid for all kinds of insurance in your State for 1985 or most recent year? _____

5. How many accident/health insurance policies or changes in existing policies did your office review in 1985? _____

6. How many licensed agents do you have in your State? _____

7. How many are licensed to sell health/accident insurance? _____

8. How many agents have had their licenses revoked for abuses related to the sale of accident/health insurance in the last year? _____

9. How many of this total number were reinstated and later allowed to sell insurance in your State? _____

10. We have heard of some cases where agents were paid more than 100 percent of annual premiums in commission. Do you have regulations which limit the amount of commissions that agents may receive? _____Yes _____No

11. Has your office issued regulations covering the following aspects of health insurance policies in general (and Medicare supplemental policies in particular) as taken from the NAIC Model bill:

		NO	YES
a.	Terms of renewability	_____	_____
b.	Initial and subsequent conditions of eligibility	_____	_____

c.	Non-duplication of coverage provisions	_____	_____
d.	Readability (clear language instead of legalese)	_____	_____
e.	Size of print	_____	_____
f.	Pre-existing conditions	_____	_____
g.	Termination of insurance	_____	_____
h.	Probation periods	_____	_____
i.	Limitations	_____	_____
j.	Exceptions	_____	_____
k.	Reductions	_____	_____
l.	Eliminations	_____	_____
m.	Requirements for replacements	_____	_____
n.	Recurrent conditions	_____	_____
o.	The definitions of such key terms as: hospital, accident, injury, physician, accidental means, total disability, nervous disorder, guaranteed renewable and non-cancellable	_____	_____
p.	Require that the prospective purchase be given a form showing coverage available under Medicare and Medicaid and how the policy would fill the gaps	_____	_____
q.	Cancellation of entire policy groups	_____	_____
r.	Minimum coverage requirements	_____	_____
s.	Limits on exclusions of pre-existing conditions	_____	_____
t.	Disclosure requirements	_____	_____
u.	Refund requirement	_____	_____
v.	Statement of major benefit gaps in Medicare Parts A and B, with a parallel description of supplemental benefits.	_____	_____

12. Do you have regulations relating to the use of pre-existing condition clauses in Medicare supplemental policies? ___Yes ___No

If yes, do these regulations

___a) eliminate pre-existing conditions clauses

___b) shorten the precondition period to 2 years

___c) shorten the period to 12-23 months

___d) shorten the period to 6 months

___e) require that language relating to pre-existing conditions to be printed prominently on the application form

___f) apply only to policies sold by mail

13. Do you have mandatory review procedures for advertisements which relate to insurance policies sold by mail? ____Yes ____No

14. Does your State have minimum loss ratios for various classes of health insurance policies? _____Yes _____No Are they mandated by law_____, regulation_____, or in guidelines_____?

    What is your minimum loss ratio for Medicare supplemental policies?_____

    What action can you take if a company exceeds minimum ratios?_____

    _____

    _____

    _____

15. Does your State mandate a no-loss right of cancellation clause to Medicare supplemental policies? ____Yes ____No

16. How many complaints has your office received in 1985? _____

17. How many of these complaints relate to accident/health insurance? _____

18. How many insurance companies have been fined or otherwise disciplined over the past three years for violations or abuses with respect to the sale of health insurance? ____ Please supply names and disposition of cases.

    _____

    _____

    _____

    _____

19. Spokesmen for the U.S. Postal Service, the Federal Trade Commission, consumers and several insurance commissioners have indicated that there are widespread abuses of elderly customers by persons selling supplemental Medicare insurance. These abuses are allegedly so prevalent that they have spawned their own vocabulary. This section of this questionnaire is to ask if you have ever received complaints of any of the following practices:

	NO	YES
1. "Wolf in sheep's clothing" - the agent fails on initial contacts with clients to disclose that he represents a for-profit insurance company. He may say he is from Medicare and wants to help seniors with any problem they may have.		
2. "Overselling" - the agent sells the clients more coverage than they need or can pay for or both (e.g. loss of employment capability for a retired individual)		
3. "More is better" - the agent represents that his policy which has a higher premium thanthe competition is better simply because of higher premium.		
4. "Duplicate sales" - the agent sells the client additional policies which in effect client.		
5. "Group policy" - the agent represents the policy as a group policy with the implication that premiums are less when in fact there is no group and the policy is the same in coverage and premium as a regular policy.		
6. "Clean sheeting" - (or failure to report material condition") - the agent fails to report preexisting health conditions of clients to company, ultimately leading to a pre-existing condition disqualification of coverage when claims are filed.		
7. "Just dropped by" - the salesman claims to stop by the client's home to collect premiums, but actually solicits new business.		
8. "I work with . . ." - the licensed salesman allows an unlicensed person to front for him.		
9. "Pie in the sky" - (or "fine print") - the agent misrepresents policy content with words like "no waiting periods," "this policy will pay for everything," etc.		
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11. "The Switch" - the agent sells the client one policy but then switches and provides another for signature at time of closing.		
12. "The add on" - the agent, after selling one policy includes in the "forms for signature" by the client a second or third policy stating when asked, ". . . you'll need this		

	NO	YES
13. "Low weekly rates" - the agent quotes premium prices on a weekly basis but closes and sells on an annual basis.		
14. "New is better" - ("Twisting" or "existing policies are garbage") - the agent encourages the client to cancel perfectly good existing policies to sell a new policy which results in additional commission fees.		
15. "The stall" - the agent delays in responding to requests by newly insured to discuss cancellation of policy. Time limits for cancellation are thereby exceeded.		
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17. "Corporate twisting" - a conspiratorial arrangement whereby two or three companies transfer aged customers between themselves. This results in the expiration of policies which are in force, in favor of newly acquired policies with waiting periods.		
18. "The government look" - agents and/or companies use advertising materials that tend to associate them with the federal Medicare or Social Security program.		
19. "The fence post policies" - the agent completes applications in the name of relatives or others, unknown to the victims. This is done to bypass underwriting rules when it is know the victims already have the maximum coverage in effect with a company.		
20. "Make the check out to me" - the agent asks that the client make the check out to him. The agent then cashes the check, and does not report the transaction to the insurance company. No policy issued.		
21. "The Medi-gap bandwagon" - the agent sells the client additional accident or life insurance as if it were part of a "comprehensive Medi-gap plan."		
22. "Postdating application" - agent postdates application to avoid maximum coverage guidelines. Net result is that client is often not covered for initially agreed period.		

23. Others (Please specify)

24. Others (Please specify)

25. Others (Please specify)

20. Would you favor any of the following options increasing the role of FEderal regulation in insurance?

    a. A bill to increase the penalties of the Federal Mail Fraud Statute for each count of mail fraud from $1,000 to $10,000 and from five years to 15 years?

    ___No ___Yes

    b. A bill to expand current benefits under Medicare to include coverage for dental care, hearing and eye care, preventive check-ups and long-term nursing home or home care, in effect abolishing the need for Medigap insurance?

    ___No ___Yes

21. An industry spokesman has been quoted as saying that Medicare supplemental policies represent the number one problem currently confronting State Insurance Commissioners. Do you agree?

    ___No ___Yes

    If no, what is your biggest problem at present?_____

    _____

    _____

22. Will you please provide the Subcommittee with three case histories of complaints with respect to Medicare supplemental policies that were resolved by your office? Please feel free to delete names of individuals or agents if you so desire.

23. Has your State produced any pamphlets or literature addressed to senior citizens providing guidance with respect to Medicare supplemental policies? ____No ____Yes

24. May we have a copy of your latest annual report?

OUR SINCERE THANKS FOR YOUR HELP

Would you like to testify before the House Select Committee on Aging, Subcommittee on Health and Long-Term Care? ____Yes ____No

Please return this questionnaire, along with additional requested information, no later than April 15, 1986, to:

Subcommittee on Health and Long-Term Care
House Annex 2, Room 377
Washington, DC 20515

CLAUDE PEPPER, FLORIDA
CHAIRMAN

JAMES J. FLORIO, NEW JERSEY
HAROLD E. FORD, TENNESSEE
MARY ROSE OAKAR, OHIO
THOMAS A. LUKEN, OHIO
DAN MICA, FLORIDA
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BRUCE F. VENTO, MINNESOTA
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RON WYDEN, OREGON
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ROBERT A. BORSKI, PENNSYLVANIA
BEN ERDREICH, ALABAMA
BUDDY MacKAY, FLORIDA
NORMAN SISISKY, VIRGINIA
EDWARD R. ROYBAL, CALIFORNIA (EX OFFICIO)

KATHLEEN GARDNER CRAVEDI
STAFF DIRECTOR

MELANIE MODLIN
ASSISTANT STAFF DIRECTOR

PETER REINSCHE
DIRECTOR OF RESEARCH

JAY CONSTANTINE
BILL MALAMUDAKIS
LEWIS W. KOLLER, M.D., D.P.H.
CONSULTANTS

(202) 226-3381

APPENDIX C

U.S. House of Representatives

SELECT COMMITTEE ON AGING
SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE
377 HOUSE OFFICE BUILDING ANNEX 2
Washington, DC 20515

May 23, 1986

RALPH REGULA, OHIO
RANKING MINORITY MEMBER

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PAUL B. HENRY, MICHIGAN
JIM KOLBE, ARIZONA
MATTHEW J. RINALDO, NEW JERSEY (EX OFFICIO)

MARK BENEDICT, J.D.
MINORITY STAFF DIRECTOR

LORI LIGHTFOOT
ASSISTANT STAFF DIRECTOR

(202) 226-3383

Dear AAA Director:

Your assistance with a matter of importance to the House Select Committee on Aging, Subcommittee on Health and Long-Term Care, would be appreciated.

As you may know, the House Aging Committee in 1978 performed an intensive investigation into supplemental Medicare insurance, also known as "Medigap" insurance. At that time flagrant abuses were observed in connection with the sale of these policies. Federal reform measures were enacted shortly thereafter.

Now, after learning of numerous cases of fraud and abuse with Medigap and observing the proliferation of television and mail advertising campaigns for these policies, the Subcommittee on Long-Term Care is reopening its investigation. We are asking for your help.

The attached questionnaire has been designed to measure the knowledge older people have about the basic attributes of health insurance. It also gives us a chance to see how much older persons know about Medicare coverage as it exists under current law.

We would like to ask that you arrange to have the enclosed 26-item questionnaire read aloud and answered at one senior center in the jurisdiction of your area agency on aging. The size of the group will be left to your discretion, although we would remind you that the larger the group, the more representative and thereful more helpful to our survey it will be. (Probably 20 persons would be minimum acceptable size.) We would ask that you make arrangements with the senior center staff promptly, as results are due back to us by June 6, 1986.

I know that the implementation of this survey will require an investment of your time and the time of a senior center staff member but I am confident it will yield results which will prove invaluable to our nation's seniors in search of health security.

Thank you in the warmest way for your assistance.

With kindest regards,

Very sincerely,

Claude Pepper
Chairman

P.S. Should questions arise, kindly contact Melanie Modlin or Kathleen Gardner Cravedi of my Subcommittee staff at (202) 226-3381.

CLAUDE PEPPER, FLORIDA
CHAIRMAN

JAMES J. FLORIO, NEW JERSEY
HAROLD E. FORD, TENNESSEE
MARY ROSE OAKAR, OHIO
THOMAS A. LUKEN, OHIO
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KATHLEEN GARDNER CRAVEDI
STAFF DIRECTOR

MELANIE MODLIN
ASSISTANT STAFF DIRECTOR

PETER BENEDEK
DIRECTOR OF RESEARCH

JAY CONSTANTINE
BELA BALAMADARIS
LEWIS H. KULLER, M.D., D.P.H.
CONSULTANTS

(202) 226-3381

U.S. House of Representatives

SELECT COMMITTEE ON AGING
SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE
377 House Office Building Annex 2
Washington, DC 20515

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MATTHEW J. RINALDO, NEW JERSEY (EX OFFICIO)

MARK BENEDICT, J.D.
MINORITY STAFF DIRECTOR

LORI LIGHTFOOT
ASSISTANT STAFF DIRECTOR

(202) 226-3383

May 23, 1986

Dear Senior Center Director:

You will please find enclosed a copy of a questionnaire that concerns health insurance and Medicare. This questionnaire has been directed to you by officials at your local Area Agency on Aging.

As you may know, the House Aging Committee in 1978 performed an intensive investigation into supplemental Medicare insurance, also known as "Medigap" insurance. At that time flagrant abuses were observed in connection with the sale of these policies. Federal reform measures were enacted shortly thereafter.

Eight years later, the Committee's Subcommittee on Health and Long-Term Care, which I chair, is reopening its investigation. We would appreciate your help.

We would like to ask that you arrange to read aloud the enclosed 26-item questionnaire before a group of seniors at your senior center in the near future. Group members can raise their hands to signal "True," "False" or "I Don't Know" in response to each question and you can then record the number of responses. The size of the group will be left to your discretion, although I would remind you that the larger the group, the more representative the sample and therefore the more helpful to us the survey will be. (Probably 15-20 persons would be the minimum acceptable size.) The survey should not take much time. Perhaps it could be given during a lunch period, or at the beginning or end of a general meeting or an activity group. I would ask that you return the completed questionnaire on or before Friday, June 6, to:

MEDIGAP SURVEY
Subcommittee on Health
and Long-Term Care
H2-377
U.S. House of Representatives
Washington, DC 20515

I know that this survey will require a small investment of time and energy from you and your senior center participants, but I am confident its results will be invaluable to our seniors in search of health security.

Thank you in the warmest way for your assistance.

With kindest regards,

Very sincerely,

Claude Pepper
Chairman

P.S. Should questions arise, kindly contact Melanie Modlin or Kathleen Gardner Cravedi of the Subcommittee staff at (202) 226-3381.

SENIOR CENTER QUESTIONNAIRE

SENIOR CENTER NAME AND ADDRESS: _____

TOTAL NUMBER OF SENIORS SURVEYED: _____

NAME AND TITLE OF PERSON ADMINISTERING QUESTIONNAIRE: _____

DATE ADMINISTERED: _____

QUESTIONS REGARDING HEALTH INSURANCE

1. A policy that promises to pay a certain amount for each day a person is hospitalized usually provides benefits to a senior citizen that are quite different from the policies designed to pay hospital and doctor expenses that are not covered by Medicare.

   _____ TRUE _____ FALSE _____ DON'T KNOW

2. An indemnity policy which promises to pay a certain amount for each day a person is hospitalized, say $40, typically will not pay more than this amount regardless of how much the hospital, doctor and drug charges are each day.

   _____ TRUE _____ FALSE _____ DON'T KNOW

3. A "pre-existing conditions" clause in a hospital insurance policy means the company can refuse to pay claims due to current illnesses related to or developing from an illness or condition you had when you bought the policy.

   _____ TRUE _____ FALSE _____ DON'T KNOW

4. Some health insurance policies -- known as dread disease policies -- will pay only if the policyholder gets a certain disease covered by the policy such as cancer.

   _____ TRUE _____ FALSE _____ DON'T KNOW

5. Health insurance policies sometimes contain a clause that excludes payment for expenses resulting from certain kinds of illnesses or diseases to certain parts of the body.

   _____ TRUE _____ FALSE _____ DON'T KNOW

6. Policies with a short time period during which claims can be denied due to pre-existing conditions are usually the most advantageous for persons 65 and over.

   _____ TRUE _____ FALSE _____ DON'T KNOW

7. If a company states that a hospital insurance policy is guaranteed renewable for life, this means the premiums can not be raised to exorbitant levels during the lifetime of the policyholder.

_____ TRUE _____ FALSE _____ DON'T KNOW

8. If a hospital insurance policy states it will pay certain hospital expenses, say so much a day for hospitalization, this means it will always pay for these expenses regardless of the cause of the illness that resulted in hospitalization.

_____ TRUE _____ FALSE _____ DON'T KNOW

9. If a policy states that certain hospital and medical expenses will be paid, the company must pay for these expenses regardless of how much they add up to during a year or during the policyholder's lifetime.

_____ TRUE _____ FALSE _____ DON'T KNOW

10. Generally, it is unwise for persons 65 and over to buy a hospital insurance policy on which the issuing company has a high loss ratio -- where a high percentage of the premiums collected are paid out in claim losses -- because the company in the future may raise premiums, cancel the policy, resist paying claims, or become financially unsound.

_____ TRUE _____ FALSE _____ DON'T KNOW

11. A person who cancels a hospital insurance policy and then immediatley buys another policy will be without full coverage for a period of time because of "pre-existing conditions" and/or "waiting period" clauses in the new policy.

_____ TRUE _____ FALSE _____ DON'T KNOW

QUESTIONS REGARDING MEDICARE

12. In order to be covered by Medicare medical insurance (Part B), most people 65 and over do not have to pay monthly premiums.

_____ TRUE _____ FALSE _____ DON'T KNOW

13. Medicare hospital insurance (Part A) does not pay for the first $492 of hospital expense incurred by a person in each Medicare benefit period.

_____ TRUE _____ FALSE _____ DON'T KNOW

14. Beginning in the 61st day in a hospital, a person covered by Medicare hospital insurance (Part A) must pay the first $123 per day of hospital expense.

_____ TRUE _____ FALSE _____ DON'T KNOW

15. A person covered by Medicare who is in the hospital longer than 90 days must pay the first $246 per day of hospital expense beginning with the 91st day, and Medicare hospital insurance (Part A) pays the balance until a lifetime total of 60 reserve days of Medicare coverage is used.

_____ TRUE _____ FALSE _____ DON'T KNOW

16. If a person is admitted to a skilled nursing facility following at least a 3-day stay in a hospital, Medicare hospital insurance (Part A) will pay for all covered services for the first 20 days in the nursing facility if certain conditions are met.

_____ TRUE _____ FALSE _____ DON'T KNOW

17. From the 21st through the 100th day in a skilled nursing facility, Medicare hospital insurance (Part A) helps pay for covered services, but the person must pay the first $61.50 per day of expense for covered services.

_____ TRUE _____ FALSE _____ DON'T KNOW

18. Medicare medical insurance (part B) will pay only what is considered to be a "reasonable" charge or fee. If a doctor or hospital charges more than this amount, the person must pay the difference.

_____ TRUE _____ FALSE _____ DON'T KNOW

19. Medicare medical insurance (Part B) helps pay for outpatient hospital care, outpatient physical therapy and speech pathology services, and home health care which are not covered by Medicare hospital insurance (Part A).

_____ TRUE _____ FALSE _____ DON'T KNOW

20. Medicare medical insurance (Part B) helps pay for doctor's services rendered in his office, in a hospital, in a skilled nursing facility, and in a person's home.

_____ TRUE _____ FALSE _____ DON'T KNOW

21. If a person is an inpatient in a hospital, Medicare medical insurance (Part B) pays 100 percent of the reasonable charges by doctors for services in radiology and pathology.

_____ TRUE _____ FALSE _____ DON'T KNOW

22. Laboratory services and other diagnostic tests, except routine examinations, are covered by Medicare medical insurance (part B).

_____ TRUE _____ FALSE _____ DON'T KNOW

23. Medicare medical insurance (Part B) does not pay for the first $75 of covered or Medicare approved medical expenses in each calendar year.

_____ TRUE _____ FALSE _____ DON'T KNOW

24. Medicare medical insurance (Part B) pays for no more than 80 percent of covered medical expenses, disregarding treatment for mental illness.

_____ TRUE _____ FALSE _____ DON'T KNOW

25. The home health care coverage under Medicare hospital insurance (Part A) and Medicare medical insurance (Part B) may be combined under some circumstances to help pay for more than 100 days of home health care in a calendar year.

_____ TRUE _____ FALSE _____ DON'T KNOW

26. In order for home health care to be covered by Medicare medical insurance (part B), the person must require part-time skilled nursing care or therapy as determined by a doctor and the person must be confined to his or her home.

_____ TRUE _____ FALSE _____ DON'T KNOW

THANK YOU VERY MUCH. PLEASE RETURN THIS COMPLETED TALLY SHEET BY JUNE 6, 1986, TO:

MEDIGAP SURVEY
Subcommittee on Health
and Long-Term Care
House Annex 2, Room 377
U.S. House of Representatives (201)
Washington, DC 20515

APPENDIX D

April 30, 1985

Honorable Margaret M. Heckler
Secretary
Department of Health & Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Ms. Heckler:

Your attention to a matter of special concern to this Subcommittee would be greatly appreciated.

Over the past several years, I have had a keen interest in the sale of health insurance to the elderly. With the advent of Medicare, private insurers developed supplemental or "Medigap" policies which are designed to cover costs not paid by the government program. Investigations conducted by committees I have chaired previously have identified abuses in the sale of these supplemental policies. The abuses have typically involved objectionable sales tactics and worthless insurance coverages. Hearings have been held on this subject in 1978 and 1981, and legislation has been passed to help curb some of these problems.

I would like to obtain an update in the issue of fraudulent insurance sales to the elderly and I request your assistance in providing details of any investigations you have undertaken in this area since 1981. Please include a description of the scheme, the number of victims, the amount of monetary loss and the outcome of any prosecutive action (e.g., verdict, sentence).

This information should reach me by May 17, 1985.

Thank you for your assistance.

With kindest regards,

Sincerely,

Claude Pepper
Chairman

APPENDIX E-1

PREMIUMS--CLAIMS--LOSS RATIO
RANKING BY PREMIUM (DESCENDING)

COMPANY	PREMIUMS EARNED LESS DIVIDENDS (DOLLARS)	CLAIMS INCURRED (DOLLARS)	LOSS RATIO
PRUDENTIAL INS. OF AMER.	2,702,628,771	2,099,725,986	78%
CONNECTICUT GENERAL LIFE	1,996,942,214	2,842,863,656	142%
AETNA LIFE INS. CO.	1,957,669,157	1,390,371,505	71%
TRAVELERS INS. CO.	1,817,293,817	1,405,793,949	77%
MUTUAL OF OMAHA INS. CO.	1,632,415,721	1,160,696,109	71%
METROPOLITAN LIFE INS. CO.	1,462,106,272	982,140,216	67%
CONTINENTAL ASSUR. CO.	928,594,628	798,698,825	86%
LINCOLN NATIONAL LIFE INS.	904,287,298	674,843,359	75%
NEW YORK LIFE INS. CO.	863,753,678	573,572,579	66%
BANKERS LIFE, IA.	804,810,831	590,624,012	73%
EQUITABLE LIFE ASSUR. SOCY.	690,289,990	568,498,921	82%
TRANSAMER. OCCIDENTAL LIFE	677,325,719	589,344,891	87%
AMER. FAMILY LIFE ASSUR.	664,070,240	270,273,609	41%
ALLSTATE LIFE INS.	627,152,318	560,695,986	89%
JOHN HANCOCK MUT. LIFE INS.	586,864,184	459,934,313	78%
PROVIDENT LIFE & ACCID. CO.	553,331,705	391,705,388	71%
GUARDIAN LIFE OF AMERICA	539,946,089	417,975,453	77%
COMBINED INS. CO. OF AMERICA	536,419,373	210,009,276	39%
GREAT-WEST LIFE ASSUR.	519,024,000	460,441,000	89%
BANKERS LIFE & CASUALTY	502,961,365	369,080,173	73%
HARTFORD LIFE & ACCIDENT	496,053,062	407,429,714	82%
STATE FARM MUTUAL AUTO.	463,010,357	343,630,626	74%
CROWN LIFE INS. CO.	462,124,000	371,443,000	80%
CONFEDERATION LIFE INS. CO.	412,072,000	395,960,000	96%
UNIONMUTUAL STOCK LIFE AM.	385,481,172	263,596,690	68%
MUTUAL BENEFIT LIFE INS.	382,154,253	288,466,753	75%
MASSACHUSETTS MUTUAL LIFE	378,717,942	272,825,632	72%
PILOT LIFE INSURANCE CO.	343,620,698	279,700,231	81%
LIFE INS. CO OF NO. AMERICAN	333,735,648	238,670,267	72%
GENERAL AMERICAN LIFE INS.	318,109,594	263,463,324	83%
FIREMENS FUND EMPLOYERS	311,313,956	223,152,667	72%
PACIFIC MUTUAL LIFE INS.	283,812,801	204,738,563	72%
SUN LIFE ASSUR. CO. CANADA	268,918,000	277,262,000	103%
TIME INSURANCE CO.	261,727,208	168,438,483	64%
MUTUAL LIFE OF NEW YORK	252,466,444	181,704,425	72%
STATE MUT. LIFE ASSUR. AMER.	238,855,974	165,507,324	69%
NATIONWIDE MUTUAL INS. CO.	238,604,700	189,720,645	80%
PURITAN LIFE INSURANCE CO.	230,797,168	198,653,210	86%
NEW ENGLAND MUTUAL LIFE	226,941,447	162,553,841	72%
PAUL REVERE LIFE INS. CO.	222,300,253	125,873,535	57%
WASHINGTON NATIONAL INSURANCE	219,780,128	135,323,412	62%
UNITED AMERICAN INS. CO.	216,629,860	94,736,773	44%
SENTRY LIFE INSURANCE CO.	208,520,584	139,157,803	67%
NATIONAL HOME LIFE ASSUR.	208,304,925	114,517,368	55%
COLONIAL PENN. LIFE INS.	207,183,112	174,722,607	84%
REPUBLIC NATL. LIFE GROUP	204,256,834	166,167,434	81%
PHYSICIANS MUTUAL INS. CO.	203,960,369	119,032,182	58%

TRAVELERS INS. CO. OF IL.	182,282,941	164,214,205	90%
GULF LIFE INSURANCE CO.	178,253,567	141,141,900	79%
LIBERTY MUTUAL INS. CO.	162,759,741	142,889,919	88%
BENEFIT TRUST LIFE INS. CO.	162,476,764	132,750,729	82%
EMPLOYERS REINS. CORP.	159,173,792	154,439,837	97%
COMMERCIAL LIFE INS. CO.	156,749,883	113,834,065	73%
JOHN ALDEN LIFE INS. CO.	156,713,543	94,532,751	60%
CANADA LIFE ASSUR. CO.	156,020,000	146,593,000	94%
N. N. INVESTORS LIFE INS. CO.	155,993,635	101,259,221	65%
UNION LABOR LIFE	155,591,654	130,467,539	84%
SAFECO LIFE INSURANCE CO.	151,067,108	95,118,856	63%
UNITED INS. CO. OF AMERICA	145,957,279	93,403,035	64%
OHIO STATE LIFE INS. CO.	145,733,225	111,023,471	76%
HOME LIFE INSURANCE CO.	142,780,666	116,789,755	82%
PHOENIX MUTUAL LIFE INS.	135,418,679	91,749,936	68%
AMERICAN COMMUNITY MUTUAL	134,185,472	97,817,736	73%
MASSACHUSETTS IND. & LIFE	133,527,315	62,411,422	47%
GOLDEN RULE INSURANCE CO.	131,094,142	73,751,534	56%
NORTHWESTERN NATL. LIFE	128,501,105	93,806,944	73%
UNITED STATES LIFE INS. CO.	128,022,102	99,633,207	78%
ALEXANDER HAMILTON LIFE	125,979,895	91,855,814	73%
CUDIS INS. SOCIETY INC.	125,786,925	75,904,358	60%
COLONIAL LIFE & ACCID. INS.	123,813,806	56,552,460	46%
INDEPENDENT LIFE & ACCID.	122,698,529	62,776,057	51%
BUSINESS MENS ASSUR. CO.	118,128,989	86,533,160	73%
PROVIDENT MUTUAL LIFE INS.	116,514,445	84,611,437	73%
TRAVELERS INDEM. OF RI.	116,064,993	91,124,969	79%
AMERICAN FAMILY MUTUAL	114,478,978	73,224,831	64%
CONTINENTAL CASUALTY CO.	111,327,238	82,561,020	74%
LIBERTY NATIONAL LIFE INS.	109,390,251	58,772,930	54%
RESERVE LIFE INSURANCE CO.	107,603,049	86,375,818	80%
LUMBERMENS MUT. CAS. CO.	104,303,718	80,631,375	77%
COLONIAL LIFE INS. OF AMER.	104,258,169	82,636,364	79%
UNION MUTUAL LIFE INS. CO.	101,324,628	79,927,962	78%
STANDARD INSURANCE CO.	98,981,206	85,976,440	87%
NATIONAL LIFE & ACCIDENT	95,882,234	55,936,457	58%
PENNSYLVANIA LIFE INS. CO.	94,923,054	48,774,600	51%
AETNA CAS. & SUR. CO. ILL.	93,562,947	100,936,284	108%
AMERICAN FIDELITY ASSUR.	92,901,576	62,662,038	67%
DURHAM LIFE INSURANCE CO.	90,557,309	63,319,933	70%
PRUDENTIAL PROP. & CAS. INS.	89,963,879	87,071,464	97%
MUTUAL SECURITY LIFE INS.	87,198,309	52,033,078	60%
FEDERATED MUTUAL INS. CO.	87,094,100	69,523,017	80%
FIREMANS FUND AMER. LIFE	82,669,574	29,659,755	36%
UNION CENTRAL LIFE INS. CO.	81,650,946	63,489,602	78%
GLOBE LIFE & ACCIDENT INS.	81,304,107	43,477,748	53%
NORTHWESTERN MUTUAL LIFE	81,136,147	38,225,661	47%
LIFE INS. CO. OF GEORGIA	80,425,387	59,098,800	73%
PAN-AMERICAN LIFE INS. CO.	78,937,833	60,960,709	77%
LONE STAR LIFE INS. CO.	77,726,097	49,524,862	64%
NRG. AMERICA LIFE REASSUR.	77,604,227	19,297,949	25%
AMERICAN LIFE INS. CO-DE	76,736,419	36,838,050	48%
COUNTRY LIFE INS. CO.	75,907,797	52,245,056	69%
AMERICAN REPUBLIC INS. CO.	73,247,888	35,656,749	49%
ST. PAUL LIFE INS. CO.	72,151,279	51,532,157	71%
NORTH AMER. LIFE & CAS. CO.	69,967,287	46,441,185	66%

UNION BANKERS INS. CO.	68,866,507	37,703,158	55%
TEACHERS INS. & ANNUITY AM.	67,852,989	65,672,279	97%
UNIONMUTUAL STOCK LIFE NY.	67,694,690	49,093,195	73%
MONTGOMERY WARD LIFE INS.	64,871,263	29,078,027	45%
CENTRAL LIFE ASSURANCE CO.	64,847,502	45,931,256	71%
SHELTER LIFE INS. CO.	64,574,668	43,829,193	68%
PROTECTIVE LIFE INS. CO.	63,605,474	49,013,300	77%
LIFE INVESTORS INS/AMER	63,400,124	38,500,144	61%
AMERICAN HERITAGE LIFE	62,738,995	45,725,069	73%
AMERICAN UNITED LIFE INS.	61,857,670	46,543,168	75%
SWISS-AM REASSURANCE CO.	61,455,759	76,261,865	124%
HORACE MANN LIFE INS. CO.	61,268,187	45,985,519	75%
MONARCH LIFE INS. CO.	60,964,578	38,946,556	64%
AMERICAN NATIONAL INSURANCE	60,156,922	42,785,364	71%
GROUP LIFE & HEALTH INS.	60,085,854	58,524,396	97%
LIBERTY LIFE INSURANCE CO.	55,720,630	41,911,417	75%
LIFE INS. CO. OF VIRGINIA	55,596,987	44,354,473	80%
AID ASSN. FOR LUTHERANS-WI	55,074,403	36,134,188	66%
FEDERAL HOME LIFE INS. CO.	55,018,110	33,900,447	62%
CENTRAL STATES HLTH & LIFE	54,897,581	27,185,984	50%
CUNA MUTUAL INS. SOCIETY	54,560,029	38,219,547	70%
GULF LIFE GROUP INS. CO.	54,235,663	49,617,889	91%
RELIANCE STANDARD LIFE	52,742,095	41,683,363	79%
SWISS REINS. CO.	52,597,136	50,013,962	95%
AETNA LIFE INS. CO. OF ILL.	52,042,203	47,459,270	91%
CENTRAL RESERVE LIFE-NA	51,434,767	29,468,332	57%
MINNESOTA MUTUAL LIFE INS.	51,329,158	32,915,523	64%
TRAVERLERS INDEMNITY	50,914,607	9,469,615	19%
CALIFORNIA WESTERN STATES	50,859,051	65,841,872	129%
EQUITABLE CAS. INS. CO.	50,565,091	57,542,085	114%
AMERICAN CHAMBERS LIFE	50,413,893	33,948,184	67%
CERTIFIED LIFE INS. CO-CA	49,202,770	25,921,746	53%
J. C. PENNEY LIFE INS. CO.	49,200,141	20,092,898	41%
AIG LIFE INSURANCE CO.	49,113,954	27,413,047	56%
BCS LIFE INSURANCE CO.	49,041,092	42,549,609	87%
AMERICAN BANKERS LIFE FLA	48,867,410	22,390,935	46%
STANDARD LIFE & ACCID. INS.	48,678,888	31,206,258	64%
NATIONAL CASUALTY CO.	48,341,698	30,067,124	62%
GREAT SOUTHERN LIFE INS.	47,075,608	36,373,766	77%
BLC INSURANCE CO.	45,028,360	29,514,373	66%
WESTERN LIFE INSURANCE CO.	44,494,014	31,085,338	70%
PHILADELPHIA AMERICAN LIFE	44,439,114	39,385,768	89%
ASSOCIATION LIFE INSURANCE CO.	44,302,851	29,639,255	67%
WOODMEN ACCIDENT & LIFE	44,274,070	32,424,217	73%
TRANSPORT LIFE INS. CO.	44,188,532	15,890,150	36%
VULCAN LIFE INSURANCE CO.	44,137,209	35,235,210	80%
GUARANTEE TRUST LIFE INS.	44,128,284	30,631,133	69%
PAUL REVERE PROT. LIFE	44,111,986	13,601,276	31%
METROPOLITAN PROP. & LIAB.	43,500,430	89,262,889	205%
INTER-OCEAN INS. CO.	43,296,579	24,768,062	57%
DOMINION LIFE ASSURANCE	43,092,000	39,938,000	93%
BANKERS LIFE OF NEB.	43,004,472	29,321,955	68%
AMERICAN MOTORISTS INS. CO.	42,887,284	32,553,447	76%
PROVIDENT ALLIANCE LIFE	42,863,764	23,647,906	55%
PRUDENTIAL REINS. CO.	42,336,990	3,591,388	8%
CONTINENTAL LIFE & ACCIDENT	41,784,132	33,454,585	80%

NORTH AMERICAN REINS. CO.	41,530,415	40,920,511	99%
NATIONAL BENEFIT LIFE	41,242,553	25,535,068	62%
RURAL SECURITY LIFE INS.	41,104,722	32,431,627	79%
COLOGNE LIFE REINS. CO.	40,900,159	30,456,941	74%
LYNDON INS CO.	40,718,000	31,848,000	78%
NATIONWIDE MUTUAL FIRE	39,299,598	31,248,106	80%
INA LIFE INSURANCE OF NY	39,295,522	29,110,986	74%
MID-CONTINENT CASUALTY CO.	38,901,115	16,105,106	41%
PHF LIFE INSURANCE CO.	38,671,405	25,133,695	65%
MUTUAL SERVICE LIFE INS.	38,444,527	28,926,901	75%
GENERAL REASSURANCE CORP.	38,057,515	21,919,150	58%
RELIANCE INSURANCE CO.	37,963,344	30,455,945	80%
PYRAMID LIFE INSURANCE CO.	37,177,325	23,414,540	63%
EDUCATORS MUTUAL LIFE INS.	37,130,639	30,118,401	81%
BANKERS UNITED LIFE ASSUR.	36,275,774	21,426,020	59%
MUTUAL PROTECTIVE INS. CO.	35,295,954	15,575,207	44%
ILLINOIS MUTUAL LIFE & CAS.	35,254,433	25,366,777	72%
CAL-FARM LIFE	35,131,270	30,536,697	87%
AMERICAN GENERAL LIFE TX.	34,774,213	31,920,211	92%
LYNDON INSURANCE CO.	34,467,324	12,239,777	36%
EXECUTIVE FUND LIFE INS.	34,328,508	13,842,449	40%
LIFE & CASUALTY OF TN.	34,318,430	21,528,455	63%
AMERICAN STATES INS. CO.	33,485,678	21,005,566	63%
PROVIDENT LIFE & CAS. INS.	33,118,357	21,284,306	64%
GEORGIA INTERNATL LIFE CO.	32,847,626	24,911,290	76%
CONNECTICUT MUTUAL LIFE	32,781,309	18,521,743	57%
RESERVE NATIONAL INS. CO.	32,665,795	15,864,809	49%
OXFORD LIFE INS. CO.	32,097,368	24,766,362	77%
SOUTHLAND LIFE INS. CO.	31,816,282	20,765,156	65%
AMERICAN HARDWARE MUTUAL	31,736,486	26,752,199	84%
NORTHBROOK LIFE INS.	31,673,840	27,939,332	88%
PIONEER LIFE INS. CO. OF IL.	31,520,933	16,936,461	54%
GREAT REPUBLIC LIFE OF CA.	31,326,108	21,386,839	68%
BANKERS MULTIPLE LINE INS.	30,854,283	18,068,252	59%
AMERICAN INTERNATL. LIFE	30,378,579	22,829,831	75%
FARMERS NEW WORLD LIFE CO.	30,348,638	24,920,444	82%
CALIFORNIA LIFE INS. CO.	29,881,401	26,337,981	88%
AETNA LIFE INS. & ANNUITY	29,794,025	16,821,256	56%
COMBINED LIFE INS. CO-NY	29,717,535	11,826,089	40%
JOHN DEERE INS. CO.	29,681,215	28,629,747	96%
AMERICAN LIFE & CAS. INS.	29,637,314	18,222,343	61%
AMALGAMATED LABOR LIFE	29,625,934	28,098,021	95%
NATIONAL FIRE INS.	29,129,798	21,602,853	74%
GREAT AMERICAN RESERVE CO.	29,106,243	22,383,348	77%
MENNONITE MUTUAL AID ASSN.	28,828,031	23,393,567	81%
ZURICH INS. CO.	28,799,180	17,295,700	60%
MERIT LIFE INS. CO.	28,521,550	13,178,947	46%
CUMBERLAND LIFE INS. TENN.	27,900,013	10,333,959	37%
COLUMBUS MUTUAL LIFE INS.	27,474,581	22,358,096	81%
HOME SECURITY LIFE INS-NC	27,319,382	21,700,778	79%
GUARANTEE MUTUAL LIFE CO.	27,248,471	21,875,557	80%
BENEFICIAL STANDARD LIFE	27,005,734	14,766,074	55%
CENTENNIAL LIFE INS. CO.	26,190,298	16,944,678	65%
GLOBE LIFE INS. CO.	26,189,900	6,070,707	23%
AMERICAN INCOME LIFE INS.	25,773,413	13,764,297	53%
NATIONAL STATES INS. CO.	25,626,852	11,558,308	45%

AMERICAN STATES LIFE INS.	25,559,161	23,423,198	92%
CALIFORNIA PHYSICIANS INS.	24,956,034	19,172,281	77%
WESTERN-SOUTHERN LIFE INS.	24,858,136	18,073,632	73%
CREDIT LIFE INSURANCE CO.	24,762,099	10,816,892	44%
WORLD INSURANCE CO.	24,734,991	14,883,396	60%
MANUFACTURERS LIFE INS. CO.	24,733,000	22,395,000	91%
MONUMENTAL LIFE INS.	24,650,735	14,201,221	58%
AMERICAN HLTH. & LIFE INS.	24,341,822	18,070,241	74%
EQUITABLE LIFE & CAS. INS.	24,274,469	12,356,093	51%
AMERICAN SECURITY LIFE	24,242,287	18,986,185	78%
CELTIC LIFE INS.-R I	23,880,306	15,763,907	66%
NATIONAL LIBERTY LIFE INS.	23,808,583	12,975,015	54%
CAMPANION LIFE INS. - NY	23,523,983	16,618,672	71%
LUMBERMENS LIFE INS. CO.	22,981,394	16,063,654	70%
CONTINENTAL AMER. LIFE INS.	22,796,027	10,730,870	47%
ALL AMERICAN LIFE	22,761,169	14,014,307	62%
NATIONAL LIFE INS. CO., VT	22,534,475	13,593,432	60%
PAULA INS. CO.	22,422,321	18,706,478	83%
UNITED FARM BUR. FAM. LIFE	22,264,186	16,951,235	76%
BLUE ALLIANCE MUTUAL INS.	22,262,185	12,446,175	56%
AMERICAN ROAD INS.	22,191,484	12,851,344	58%
IDS LIFE INS. CO.	22,156,995	12,386,444	56%
UNITED WISCONSIN INS. CO.	21,573,000	16,788,819	78%
COMMONWEALTH LIFE INS. - KY	21,412,722	14,214,250	66%
MACCABEES MUTUAL LIFE	20,658,823	12,976,304	63%
UNITED LIFE & ACCIDENT	20,578,024	12,901,878	63%
SECURITY OF AMER. LIFE INS.	20,415,038	12,336,451	60%
GEORGIA CAS. & SUR. CO.	20,299,682	8,682,218	43%
FARMLAND LIFE INS. CO.	20,165,347	14,393,236	71%
MICHIGAN LIFE INS. CO.	19,990,108	17,548,777	88%
APPLACHIAN NATL. LIFE INS.	19,696,617	13,488,030	68%
GEORGE WASHINGTON LIFE CO.	19,591,951	9,989,373	51%
INTERCONTINENTAL LIFE - PR	19,526,098	14,499,958	74%
ORANGE STATE LIFE & HLTH.	19,275,443	12,691,089	66%
PEKIN LIFE INS. CO.	19,125,395	11,897,802	62%
LAMAR LIFE INS. CO.	19,102,487	14,333,128	75%
NORTH CENTRAL LIFE INS. CO.	19,083,200	6,089,407	32%
COMMERCIAL BANKERS LIFE	19,059,916	13,452,904	71%
EQUITY NATIONAL LIFE INS.	19,029,890	7,803,195	41%
AIU INS. CO.	18,937,872	7,660,618	40%
BOSTON MUTUAL LIFE	18,888,679	11,555,992	61%
PACIFIC HERITAGE ASSUR. CO.	18,877,546	12,502,620	66%
LIBERTY LIFE ASSUR./BOSTON	18,821,353	16,579,960	88%
MONUMENTAL GENL. INS. CO.	18,709,626	10,069,065	54%
MASSACHUSETTS CAS. INS.	18,398,816	1,859,129	64%
OLD AMERICAN INS. CO.	18,300,907	8,546,542	47%
UNITED FIDELITY LIFE INS.	18,225,785	13,422,878	74%
LIBERTY MUT. FIRE INS. CO.	18,084,417	15,876,658	88%
EAGLE LIFE INS. CO.	18,059,696	7,196,819	40%
FIRST HORIZON INS.	18,036,741	8,589,223	48%
KENTUCKY CENTRAL LIFE	17,827,141	11,027,365	62%
CONTINENTAL GENERAL INS.	17,756,872	7,911,476	45%
LUTHERAN BROTHERHOOD	17,640,090	8,356,433	47%
BANNER LIFE INS.	17,300,135	6,374,875	37%
CENTRAL NATL. INS. CO. - OMAHA	17,134,868	2,129,270	12%
DEPENDABLE LIFE INS. CO. - FL.	17,133,126	13,241,052	77%

FIRST DELAWARE LIFE	17,060,716	14,425,722	85%
AMERICAN GENERAL LIFE DE.	16,926,090	10,879,695	64%
HARBOR INSURANCE CO.	16,633,096	11,137,648	67%
NATIONAL FARMERS UNION	16,622,861	12,653,016	76%
UNION NATL. LIFE INS. OF LA	16,621,736	5,740,988	35%
AMERICAN SERVICE LIFE - TX	16,385,994	8,213,300	50%
UNION LIFE INS. CO.	16,348,614	13,324,899	82%
FOREMOST LIFE INS.	15,925,791	10,243,670	64%
SMA LIFE ASSUR. CO.	15,746,765	10,102,861	64%
COOPERANTS MUT. LIFE SOCY.	15,722,000	11,788,000	75%
CONNECTICUT NATIONAL	15,591,951	10,336,217	66%
NATIONAL TRAVELERS LIFE	15,497,656	11,426,856	74%
CONSUMER BENEFIT LIFE	15,484,934	11,141,742	72%
SENTRY INS. CO. A. MUTUAL	14,915,804	12,687,068	85%
INTERCONTINENTAL LIFE INS.	14,910,224	8,002,686	54%
INTRAMERICA LIFE INS. CO.	14,755,061	13,819,958	94%
WINTERTHUR SWISS INS. CO.	14,716,036	9,267,010	63%
HOME INS. CO.	14,684,608	9,408,031	64%
BEST LIFE ASSUR. CO. CA	14,419,430	10,111,648	70%
LIFE INS. CO. OF SOUTHWEST	14,341,498	10,634,593	74%
CENTRAL STATES INDEMNITY	14,198,432	3,922,616	28%
PENINSULAR LIFE INS. CO.	14,054,904	5,590,015	40%
PROVIDENT INDEMNITY LIFE	13,853,752	8,718,911	63%
NATL. HOME LIFE ASSUR. - NY	13,726,241	7,346,332	54%
NORTH AMER. CO/L&H INS.	13,685,106	18,749,564	137%
LOYAL AMERICAN LIFE INS.	13,541,179	5,089,490	38%
WORLD SERVICE OF COLORADO	13,511,467	13,670,339	101%
NORTH CAROLINA MUT. LIFE	13,391,539	10,669,725	80%
SAVERS LIFE INS. OF AMER.	13,332,770	8,712,080	65%
FIDELITY SECURITY LIFE CO.	13,153,025	3,924,131	30%
MUTUAL SAVINGS LIFE INS.	12,717,679	5,408,379	43%
FIRST NATIONAL LIFE - AL	12,595,025	8,919,333	71%
AMERICAN MUTUAL LIAB. INS.	12,568,497	12,277,928	98%
MINISTERS LIFE A MUTUAL	12,465,911	10,941,580	88%
BERKSHIRE LIFE INS. CO.	12,400,729	3,255,781	26%
UNITED EQUITABLE INS.	12,198,853	4,664,134	38%
PROVIDENT GENERAL INS. CO.	12,186,135	15,734,670	129%
NEW ENGLAND GEN. LIFE INS.	12,108,928	13,961,242	115%
HERITAGE LIFE INS. CO.	12,052,051	4,376,167	36%
CONTINENTAL LIFE INS. TX	12,023,789	4,431,757	37%
AMERICAN CASUALTY CO.	11,994,624	8,895,292	74%
AMERICAN INTEGRITY INS. CO.	11,954,742	3,548,255	30%
LIFE ASSUR. CO. OF PA.	11,887,297	1,180,662	10%
AMERICAN STANDARD L & A	11,807,093	6,581,537	56%
AMERICAN HOME ASSUR. CO.	11,654,764	5,670,763	49%
OLD SOUTHERN LIFE INS. CO.	11,640,231	6,135,845	53%
INS. CO. OF NORTH AMERICA	11,608,492	5,715,892	49%
SIERRA GENERAL LIFE INS.	11,554,583	10,683,251	92%
VETERANS LIFE INS. CO.	11,527,676	6,353,360	55%
SECURITY MUTUAL LIFE, NE	11,482,174	10,545,745	92%
INVESTORS HERITAGE LIFE	11,347,089	7,787,039	69%
WABASH LIFE INS. CO.	11,316,909	6,626,654	59%
ZALE LIFE INS. CO.	11,267,808	6,384,109	57%
AMERICAN BANKERS INS. CO.	11,256,691	6,995,852	62%
WORLD LIFE & HEALTH INS.	11,243,961	5,108,198	45%
FIRST CONTINENTAL L & A INS.	11,199,888	5,858,328	52%

IMPERIAL CAS. & INDEMN. CO.	11,104,074	4,548,758	41%
PEERLESS INS. CO.	10,911,258	8,927,586	82%
AMERICAN INDEPENDENT INS.	10,876,697	5,949,859	55%
UNITED FOUNDERS LIFE - OK	10,838,264	6,884,699	64%
SPRINGFIELD LIFE INS.	10,766,254	7,151,245	66%
SECURITY MUTUAL LIFE NY	10,721,919	7,971,778	74%
AMERICAN WAY LIFE INS.	10,720,882	892,677	8%
MIDLAND MUTUAL LIFE INS.	10,634,469	3,358,137	32%
NATIONAL SAVINGS LIFE - TN	10,598,127	7,431,457	70%
FORUM INSURANCE CO.	10,501,509	5,912,237	56%
JMIC LIFE INS. CO.	10,478,972	1,988,264	19%
MIC LIFE INS. CORP.	10,409,129	5,901,638	57%
GERLING GLOBAL REINS. CORP.	10,359,204	8,652,105	84%
ACADEMY LIFE INS. CO.	10,318,354	6,780,773	66%
AMER. MANUFACTURERS MUT.	10,296,138	7,959,729	77%
RURAL MUTUAL INS.	10,102,229	8,244,528	82%
ARCADIA INSURANCE CO.	10,089,785	4,823,666	48%

APPENDIX E-2

PREMIUMS--CLAIMS--LOSS RATIO
RANKING BY LOSS RATIO (DESCENDING)

COMPANY	PREMIUMS EARNED LESS DIVIDENDS (DOLLARS)	CLAIMS INCURRED (DOLLARS)	LOSS RATIO
METROPOLITAN PROP. & LIAB.	43,500,430	89,262,889	205%
CONNECTICUT GENERAL LIFE	1,996,942,214	2,842,863,656	142%
NORTH AMER. CO/L&H INS.	13,685,106	18,749,564	137%
CALIFORNIA WESTERN STATES	50,859,051	65,841,872	129%
PROVIDENT GENERAL INS. CO.	12,186,135	15,734,670	129%
SWISS-AM REASSURANCE CO.	61,455,759	76,261,865	124%
NEW ENGLAND GEN. LIFE INS.	12,108,928	13,961,242	115%
EQUITABLE CAS. INS. CO.	50,565,091	57,542,085	114%
AETNA CAS. & SUR. OF ILL.	93,562,947	100,936,284	108%
SUN LIFE ASSUR. CO. CANADA	268,918,000	277,262,000	103%
WORLD SERVICE OF COLORADO	13,511,467	13,670,339	101%
NORTH AMERICAN REINS. CO.	41,530,415	40,920,511	99%
AMERICAN MUTUAL LIAB. INS.	12,568,497	12,277,928	98%
GROUP LIFE & HEALTH INS.	60,085,854	58,524,396	97%
EMPLOYERS REINS. CORP.	159,173,792	154,439,837	97%
TEACHERS INS. & ANNUITY AM.	67,852,989	65,672,279	97%
PRUDENTIAL PROP. & CAS. INS.	89,963,879	87,071,464	97%
JOHN DEERE INS. CO.	29,681,215	28,629,747	96%
CONFEDERATION LIFE INS. CO.	412,072,000	395,960,000	96%
SWISS REINS. CO.	52,597,136	50,013,962	95%
AMALGAMATED LABOR LIFE	29,625,934	28,098,021	95%
CANADA LIFE ASSUR. CO.	156,020,000	146,593,000	94%
INTRAMERICA LIFE INS. CO.	14,755,061	13,819,958	94%
DOMINION LIFE ASSURANCE	43,092,000	39,938,000	93%
SIERRA GENERAL LIFE INS.	11,554,583	10,683,251	92%
SECURITY MUTUAL LIFE, NE	11,482,174	10,545,745	92%
AMERICAN GENERAL LIFE TX.	34,774,213	31,920,211	92%
AMERICAN STATES LIFE INS.	25,559,161	23,423,198	92%
GULF LIFE GROUP INS. CO.	54,235,663	49,617,889	91%
AETNA LIFE INS. CO. OF ILL.	52,042,203	47,459,270	91%
MANUFACTURERS LIFE INS. CO.	24,733,000	22,395,000	91%
TRAVELERS INS. CO. OF IL.	182,282,941	164,214,205	90%
ALLSTATE LIFE INS.	627,152,318	560,695,986	89%
GREAT-WEST LIFE ASSUR.	519,024,000	460,441,000	89%
PHILADELPHIA AMERICAN LIFE	44,439,114	39,385,768	89%
NORTHBROOK LIFE INS.	31,673,840	27,939,332	88%
CALIFORNIA LIFE INS. CO.	29,881,401	26,337,981	88%
LIBERTY LIFE ASSUR./BOSTON	18,821,353	16,579,960	88%
LIBERTY MUTUAL INS. CO.	162,759,741	142,689,919	88%
LIBERTY MUT. FIRE INS. CO.	18,084,417	15,876,658	88%
MICHIGAN LIFE INS. CO.	19,990,108	17,548,777	88%
MINISTERS LIFE & MUTUAL	12,465,911	10,941,580	88%
TRANSAMER. OCCIDENTALLIFE	677,325,719	589,344,891	87%
CAL-FARM LIFE	35,131,270	30,536,697	87%
STANDARD INSURANCE CO.	98,981,206	85,976,440	87%
BCS LIFE INSURANCE CO.	49,041,092	42,549,609	87%
PURITAN LIFE INSURANCE CO.	230,797,168	198,653,210	86%

CONTINENTAL ASSUR. CO.	928,594,628	798,698,825	86%
SENTRY INS. CO. A. MUTUAL	14,915,804	12,687,068	85%
FIRST DELAWARE LIFE	17,060,716	14,425,722	85%
COLONIAL PENN. LIFE INS.	207,183,112	174,722,607	84%
AMERICAN HARDWARE MUTUAL	31,736,486	26,752,199	84%
UNION LABOR LIFE	155,591,654	130,467,539	84%
GERLING GLOBAL REINS. CORP.	10,359,204	8,652,105	84%
PAULA INS. CO.	22,422,321	18,706,478	83%
GENERAL AMERICAN LIFE INS.	318,109,594	263,463,324	83%
EQUITABLE LIFE ASSUR. SOCY.	690,289,990	568,498,921	82%
HARTFORD LIFE & ACCIDENT	496,053,062	407,429,714	82%
FARMERS NEW WORLD LIFE CO.	30,348,638	24,920,444	82%
PEERLESS INS. CO.	10,911,258	8,927,586	82%
HOME LIFE INSURANCE CO.	142,780,666	116,789,755	82%
BENEFIT TRUST LIFE INS. CO.	162,476,764	132,750,729	82%
RURAL MUTUAL INS.	10,102,229	8,244,528	82%
UNION LIFE INS. CO.	16,348,614	13,324,899	82%
PILOT LIFE INSURANCE CO.	343,620,698	279,700,231	81%
COLUMBUS MUTUAL LIFE INS.	27,474,581	22,358,096	81%
REPUBLIC NATL. LIFE GROUP	204,256,834	166,167,434	81%
MENNONITE MUTUAL AID ASSN.	28,828,031	23,393,567	81%
EDUCATORS MUTUAL LIFE INS.	37,130,639	30,118,401	81%
CROWN LIFE INS. CO.	462,124,000	371,443,000	80%
GUARANTEE MUTUAL LIFE CO.	27,248,471	21,875,557	80%
RESERVE LIFE INSURANCE CO.	107,603,049	86,375,818	80%
RELIANCE INSURANCE CO.	37,963,344	30,455,945	80%
CONTINENTAL LIFE & ACCIDENT	41,784,132	33,454,585	80%
VULCAN LIFE INSURANCE CO.	44,137,209	35,235,210	80%
FEDERATED MUTUAL INS. CO.	87,094,100	69,523,017	80%
LIFE INS. CO. OF VIRGINIA	55,596,987	44,354,473	80%
NORTH CAROLINA MUT. LIFE	13,391,539	10,669,725	80%
NATIONWIDE MUTUAL INS. CO.	238,604,700	189,720,645	80%
NATIONWIDE MUTUAL FIRE	39,299,598	31,248,106	80%
HOME SECURITY LIFE INS-NC	27,319,382	21,700,778	79%
COLONIAL LIFE INS. OF AMER.	104,258,169	82,636,364	79%
GULF LIFE INSURANCE CO.	178,253,567	141,141,960	79%
RELIANCE STANDARD LIFE	52,742,095	41,683,363	79%
RURAL SECURITY LIFE INS.	41,104,722	32,431,627	79%
UNION MUTUAL LIFE INS. CO.	101,324,628	79,927,962	79%
TRAVELERS INDEM. OF RI.	116,064,999	91,124,969	79%
JOHN HANCOCK MUT. LIFE INS.	586,864,184	459,934,313	78%
AMERICAN SECURITY LIFE	24,242,287	18,986,185	78%
LYNDON INS CO.	40,718,000	31,848,000	78%
UNITED STATES LIFE INS. CO.	128,022,102	99,633,207	78%
UNITED WISCONSIN INS. CO.	21,573,000	16,788,819	78%
UNION CENTRAL LIFE INS. CO.	81,650,946	63,489,602	78%
PRUDENTIAL INS. OF AMER.	2,702,628,771	2,099,725,986	78%
GUARDIAN LIFE OF AMERICA	539,946,089	417,975,453	77%
TRAVELERS INS. CO.	1,817,293,817	1,405,793,949	77%
AMER. MANUFACTURERS MUT.	10,296,138	7,959,729	77%
DEPENDABLE LIFE INS. CO. - FL.	17,133,126	13,241,052	77%
GREAT SOUTHERN LIFE INS.	47,075,608	36,373,766	77%
PAN-AMERICAN LIFE INS. CO.	78,937,833	60,960,709	77%
LUMBERMENS MUT. CAS. CO.	104,303,718	80,531,375	77%
OXFORD LIFE INS. CO.	32,097,368	24,766,362	77%
PROTECTIVE LIFE INS. CO.	63,605,474	49,013,300	77%

GREAT AMERICAN RESERVE CO.	29,106,243	22,383,348	77%
CALIFORNIA PHYSICIANS INS.	24,956,034	19,172,281	77%
OHIO STATE LIFE INS. CO.	145,733,225	111,023,471	76%
UNITED FARM BUR. FAM. LIFE	22,264,186	16,951,235	76%
NATIONAL FARMERS UNION	16,622,861	12,653,016	76%
AMERICAN MOTORISTS INS. CO.	42,887,284	32,553,447	76%
GEORGIA INTERNATL LIFE CO.	32,847,626	24,911,290	76%
MUTUAL BENEFIT LIFE INS.	382,154,253	288,466,753	75%
MUTUAL SERVICE LIFE INS.	38,444,327	28,926,901	75%
AMERICAN UNITED LIFE INS.	61,857,670	46,543,168	75%
LIBERTY LIFE INSURANCE CO.	55,720,630	41,911,417	75%
AMERICAN INTERNATL. LIFE	30,378,579	22,829,831	75%
HORACE MANN LIFE INS. CO.	61,268,187	45,985,5 9	75%
LAMAR LIFE INS. CO.	19,102,487	14,333,128	75%
COOPERANTS MUT. LIFE SOCY.	15,722,000	11,788,000	75%
LINCOLN NATIONAL LIFE INS.	904,287,298	674,843,359	75%
COLOGNE LIFE REINS. CO.	40,900,159	30,456,941	74%
SECURITY MUTUAL LIFE NY	10,721,919	7,971,778	74%
INTERCONTINENTAL LIFE - PR	19,526,098	14,499,958	74%
AMERICAN HLTH. & LIFE INS.	24,341,822	18,070,241	74%
STATE FARM MUTUAL AUTO.	463,010,357	343,630,626	74%
NATIONAL FIRE INS.	29,129,798	2 ,602,853	74%
CONTINENTAL CASUALTY CO.	111,327,238	82,561,020	74%
AMERICAN CASUALTY CO.	11,994,624	8,895,292	74%
LIFE INS. CO. OF SOUTHWEST	14,341,498	10,634,593	74%
INA LIFE INSURANCE OF NY	39,295,522	29,110,986	74%
NATIONAL TRAVELERS LIFE	15,497,656	11,426,856	74%
UNITED FIDELITY LIFE INS.	18,225,785	13,422,878	74%
LIFE INS. CO. OF GEORGIA	80,425,387	59,098,800	73%
BANKERS LIFE, IA.	804,810,831	590,624,012	73%
BANKERS LIFE & CASUALTY	502,961,365	369,080,173	73%
BUSINESS MENS ASSUR. CO.	118,128,989	86,533,160	73%
WOODMEN ACCIDENT & LIFE	44,274,070	32,424,217	73%
NORTHWESTERN NATL. LIFE	128,501,105	93,806,944	73%
ALEXANDER HAMILTON LIFE	125,979,895	91,855,814	73%
AMERICAN COMMUNITY MUTUAL	134,185,472	97,817,736	73%
AMERICAN HERITAGE LIFE	62,738,995	45,725,069	73%
UNIONMUTUAL STOCK LIFE NY.	67,694,690	49,293,195	73%
WESTERN-SOUTHERN LIFE INS.	24,858,136	18,073,632	73%
COMMERCIAL LIFE INS. CO.	156,749,883	113,834,065	73%
PROVIDENT MUTUAL LIFE INS.	116,514,445	84,611,437	73%
PACIFIC MUTUAL LIFE INS.	283,812,801	204,738,563	72%
MASSACHUSETTS MUTUAL LIFE	378,717,942	272,825,632	72%
MUTUAL LIFE OF NEW YORK	252,466,444	181,704,425	72%
ILLINOIS MUTUAL LIFE & CAS.	35,254,433	25,366,777	72%
CONSUMER BENEFIT LIFE	15,484,934	11,141,742	72%
FIREMENS FUND EMPLOYERS	311,313,956	223,152,667	72%
NEW ENGLAND MUTUAL LIFE	226,941,447	162,553,841	72%
LIFE INS. CO OF NO. AMERICAN	333,735,648	238,670,267	72%
ST. PAUL LIFE INS. CO.	72,151,279	51,532,157	71%
FARMLAND LIFE INS. CO.	20,165,347	14,393,236	71%
AMERICAN NATIONAL INSURANCE	60,156,922	42,785,364	71%
MUTUAL OF OMAHA INS. CO.	1,632,415,721	1,160,696,109	71%
AETNA LIFE INS. CO.	1,957,669,157	1,390,371,505	71%
CENTRAL LIFE ASSURANCE CO.	64,847,502	45,931,256	71%
FIRST NATIONAL LIFE - AL	12,595,025	8,919,333	71%

WINTERTHUR SWISS INS. CO.	14,716,036	9,267,010	63%
SAFECO LIFE INSURANCE CO.	151,067,108	95,118,856	63%
PROVIDENT INDEMNITY LIFE	13,853,752	8,718,911	63%
MACCABEES MUTUAL LIFE	20,658,823	12,976,304	63%
LIFE & CASUALTY OF TN.	34,318,430	21,528,455	63%
AMERICAN STATES INS. CO.	33,485,678	21,005,566	63%
UNITED LIFE & ACCIDENT	20,578,024	12,901,878	63%
PEKIN LIFE INS. CO.	19,125,395	11,897,802	62%
NATIONAL CASUALTY CO.	48,341,698	30,067,124	62%
AMERICAN BANKERS INS. CO.	11,256,691	6,995,852	62%
NATIONAL BENEFIT LIFE	41,242,553	25,535,068	62%
KENTUCKY CENTRAL LIFE	17,827,141	11,027,365	62%
FEDERAL HOME LIFE INS. CO.	55,018,110	33,900,447	62%
WASHINGTON NATIONAL INSURANCE	219,780,128	135,323,412	62%
ALL AMERICAN LIFE	22,761,169	14,014,307	62%
AMERICAN LIFE & CAS. INS.	29,637,314	18,222,343	61%
BOSTON MUTUAL LIFE	18,888,679	11,555,992	61%
LIFE INVESTORS INS/AMER	63,400,124	38,500,144	61%
SECURITY OF AMER. LIFE INS.	20,415,038	12,336,451	60%
CUDIS INS. SOCIETY INC.	125,786,925	75,904,358	60%
NATIONAL LIFE INS. CO., VT	22,534,475	13,593,432	60%
JOHN ALDEN LIFE INS. CO.	156,713,543	94,532,751	60%
WORLD INSURANCE CO.	24,734,991	14,883,396	60%
ZURICH INS. CO.	28,799,180	17,295,700	60%
MUTUAL SECURITY LIFE INS.	87,198,309	52,033,072	60%
BANKERS UNITED LIFE ASSUR.	36,275,774	21,426,020	59%
BANKERS MULTIPLE LINE INS.	30,854,283	18,068,252	59%
WABASH LIFE INS. CO.	11,316,909	6,626,654	59%
PHYSICIANS MUTUAL INS. CO.	203,960,369	119,032,182	58%
NATIONAL LIFE & ACCIDENT	95,882,234	55,936,457	58%
AMERICAN ROAD INS.	22,191,484	12,851,344	58%
MONUMENTAL LIFE INS.	24,650,735	14,201,221	58%
GENERAL REASSURANCE CORP.	38,057,515	21,919,150	58%
CENTRAL RESERVE LIFE-NA	51,434,767	29,468,332	57%
INTER-OCEAN INS. CO.	43,296,579	24,768,062	57%
MIC LIFE INS. CORP.	10,409,129	5,901,638	57%
ZALE LIFE INS. CO.	11,267,808	6,384,109	57%
PAUL REVERE LIFE INS. CO.	222,300,253	125,873,535	57%
CONNECTICUT MUTUAL LIFE	32,781,309	18,521,743	57%
AETNA LIFE INS. & ANNUITY	29,794,025	16,821,256	56%
FORUM INSURANCE CO.	10,501,509	5,912,237	56%
GOLDEN RULE INSURANCE CO.	131,094,142	73,751,534	56%
BLUE ALLIANCE MUTUAL INS.	22,262,185	12,446,175	56%
IDS LIFE INS. CO.	22,156,995	12,386,444	56%
AIG LIFE INSURANCE CO.	49,113,954	27,413,047	56%
AMERICAN STANDARD L & A	11,807,093	6,581,537	56%
PROVIDENT ALLIANCE LIFE	42,863,764	23,647,906	55%
VETERANS LIFE INS. CO.	11,527,676	6,353,360	55%
NATIONAL HOME LIFE ASSUR.	208,304,925	114,517,368	55%
UNION BANKERS INS. CO.	68,866,307	37,703,158	55%
AMERICAN INDEPENDENT INS.	10,876,697	5,949,859	55%
BENEFICIAL STANDARD LIFE	27,005,734	14,766,074	55%
NATIONAL LIBERTY LIFE INS.	23,808,583	12,975,015	54%
MONUMENTAL GENL. INS. CO.	18,709,626	10,069,065	54%
PIONEER LIFE INS. CO. OF IL.	31,520,933	16,936,461	54%
LIBERTY NATIONAL LIFE INS.	109,390,251	58,772,930	54%

PROVIDENT LIFE & ACCID. CO.	553,331,705	391,705,388	71%
CAMPANION LIFE INS. - NY	23,523,983	16,618,672	71%
COMMERCIAL BANKERS LIFE	19,059,916	13,452,904	71%
BEST LIFE ASSUR. CO. CA	14,419,430	10,111,648	70%
NATIONAL SAVINGS LIFE - TN	10,598,127	7,431,457	70%
CUNA MUTUAL INS. SOCIETY	54,560,029	38,219,547	70%
DURHAM LIFE INSURANCE CO.	90,557,309	63,319,933	70%
LUMBERMENS LIFE INS. CO.	22,981,394	16,065,654	70%
WESTERN LIFE INSURANCE CO.	44,494,014	31,085,338	70%
GUARANTEE TRUST LIFE INS.	44,128,284	30,631,133	69%
STATE MUT. LIFE ASSUR. AMER.	238,855,974	165,507,324	69%
COUNTRY LIFE INS. CO.	75,907,797	52,245,056	69%
INVESTORS HERITAGE LIFE	11,347,089	7,787,039	69%
APPLACHIAN NATL. LIFE INS.	19,696,617	13,488,030	68%
UNIONMUTUAL STOCK LIFE AM.	385,481,172	263,598,690	68%
GREAT REPUBLIC LIFE OF CA.	31,326,108	21,386,839	68%
BANKERS LIFE OF NEB.	43,004,472	29,321,955	68%
SHELTER LIFE INS. CO.	64,574,668	43,829,193	68%
PHOENIX MUTUAL LIFE INS.	135,418,679	91,749,936	68%
AMERICAN FIDELITY ASSUR.	92,901,576	62,662,038	67%
AMERICAN CHAMBERS LIFE	50,413,893	33,948,184	67%
METROPOLITAN LIFE INS. CO.	1,462,106,272	982,140,216	67%
HARBOR INSURANCE CO.	16,633,096	11,137,648	67%
ASSOCIATION LIFE INSURANCE CO.	44,302,851	29,639,255	67%
SENTRY LIFE INSURANCE CO.	208,520,584	139,157,803	67%
SPRINGFIELD LIFE INS.	10,766,254	7,151,245	66%
NEW YORK LIFE INS. CO.	863,753,678	573,572,579	66%
COMMONWEALTH LIFE INS. - KY	21,412,722	14,214,250	66%
NORTH AMER. LIFE & CAS. CO.	69,967,287	46,441,185	66%
CONNECTICUT NATIONAL	15,591,951	10,336,217	66%
PACIFIC HERITAGE ASSUR. CO.	18,877,546	12,502,620	66%
CELTIC LIFE INS.-R I	23,880,306	15,763,907	66%
ORANGE STATE LIFE & HLTH.	19,275,443	12,691,089	66%
ACADEMY LIFE INS. CO.	10,318,354	6,780,773	66%
AID ASSN. FOR LUTHERANS-WI	55,074,403	36,134,188	66%
BLC INSURANCE CO.	45,028,360	29,514,373	66%
SAVERS LIFE INS. OF AMER.	13,332,770	8,712,080	65%
SOUTHLAND LIFE INS. CO.	31,816,282	20,765,156	65%
PHF LIFE INSURANCE CO.	38,671,405	25,133,695	65%
N. N. INVESTORS LIFE INS. CO.	155,993,635	101,259,221	65%
CENTENNIAL LIFE INS. CO.	26,190,298	16,944,678	65%
MASSACHUSETTS CAS. INS.	18,398,816	11,859,129	64%
TIME INSURANCE CO.	261,727,208	168,438,483	64%
FOREMOST LIFE INS.	15,925,791	10,243,670	64%
AMERICAN GENERAL LIFE DE.	16,926,090	10,879,695	64%
PROVIDENT LIFE & CAS. INS.	33,118,357	21,284,306	64%
SMA LIFE ASSUR. CO.	15,746,765	10,102,861	64%
MINNESOTA MUTUAL LIFE INS.	51,329,158	32,915,523	64%
STANDARD LIFE & ACCID. INS.	48,678,888	31,206,258	64%
HOME INS. CO.	14,684,608	9,408,031	64%
UNITED INS. CO. OF AMERICA	145,957,279	93,403,035	64%
AMERICAN FAMILY MUTUAL	114,478,978	73,224,831	64%
MONARCH LIFE INS. CO.	60,964,578	38,946,356	64%
LONE STAR LIFE INS. CO.	77,726,097	49,524,862	64%
UNITED FOUNDERS LIFE - OK	10,838,264	6,884,699	64%
PYRAMID LIFE INSURANCE CO.	37,177,325	23,414,540	63%

INTERCONTINENTAL LIFE INS.	14,910,204	8,002,680	54%
NATL. HOME LIFE ASSUR. - NY	13,726,241	7,346,332	54%
GLOBE LIFE & ACCIDENT INS.	81,304,107	43,477,748	53%
AMERICAN INCOME LIFE INS.	25,773,413	13,764,297	53%
OLD SOUTHERN LIFE INS. CO.	11,640,231	6,135,845	53%
CERTIFIED LIFE INS. CO-CA	49,202,770	25,921,746	53%
FIRST CONTINENTAL L & A INS.	11,199,888	5,858,328	52%
PENNSYLVANIA LIFE INS. CO.	94,923,054	48,774,600	51%
INDEPENDENT LIFE & ACCID.	122,698,529	62,776,057	51%
GEORGE WASHINGTON LIFE CO.	19,591,951	9,989,373	51%
EQUITABLE LIFE & CAS. INS.	24,274,469	12,356,093	51%
AMERICAN SERVICE LIFE - TX	16,385,994	8,213,300	50%
CENTRAL STATES HLTH & LIFE	54,897,581	27,185,984	50%
INS. CO. OF NORTH AMERICA	11,608,492	5,715,892	49%
AMERICAN REPUBLIC INS. CO.	73,247,888	35,656,749	49%
AMERICAN HOME ASSUR. CO.	11,654,764	5,670,763	49%
RESERVE NATIONAL INS. CO.	32,665,795	15,864,809	49%
AMERICAN LIFE INS. CO-DE	76,736,419	36,838,050	48%
ARCADIA INSURANCE CO.	10,089,785	4,823,666	48%
FIRST HORIZON INS.	18,036,741	8,589,223	48%
LUTHERAN BROTHERHOOD	17,640,090	8,356,433	47%
NORTHWESTERN MUTUAL LIFE	81,136,147	38,225,661	47%
CONTINENTAL AMER. LIFE INS.	22,796,027	10,730,870	47%
MASSACHUSETTS IND. & LIFE	133,527,315	62,411,422	47%
OLD AMERICAN INS. CO.	18,300,907	8,546,542	47%
MERIT LIFE INS. CO.	28,521,550	13,178,947	46%
AMERICAN BANKERS LIFE FLA	48,867,410	22,390,935	46%
COLONIAL LIFE & ACCID. INS.	123,813,806	56,552,460	46%
WORLD LIFE & HEALTH INS.	11,243,961	5,108,198	45%
NATIONAL STATES INS. CO.	25,626,852	11,558,308	45%
MONTGOMERY WARD LIFE INS.	64,871,263	29,078,027	45%
CONTINENTAL GENERAL INS.	17,756,872	7,911,476	45%
MUTUAL PROTECTIVE INS. CO.	35,295,954	15,575,207	44%
UNITED AMERICAN INS. CO.	216,629,860	94,736,773	44%
CREDIT LIFE INSURANCE CO.	24,762,099	10,816,892	44%
GEORGIA CAS. & SUR. CO.	20,299,682	8,682,218	43%
MUTUAL SAVINGS LIFE INS.	12,717,679	5,408,379	43%
MID-CONTINENT CASUALTY CO.	38,901,115	16,105106	41%
EQUITY NATIONAL LIFE INS.	19,029,890	7,803,195	41%
IMPERIAL CAS. & INDEMN. CO.	11,104,674	4,548,758	41%
J. C. PENNEY LIFE INS. CO.	49,200,141	20,092,898	41%
AMER. FAMILY LIFE ASSUR.	664,070,240	270,273,609	41%
AIU INS. CO.	18,937,872	7,660,618	40%
EXECUTIVE FUND LIFE INS.	34,328,508	13,842,449	40%
EAGLE LIFE INS. CO.	18,059,696	7,196,819	40%
COMBINED LIFE INS. CO-NY	29,717,535	11,826,089	40%
PENINSULAR LIFE INS. CO.	14,054,904	5,590,015	40%
COMBINED INS. CO. OF AMERICA	536,419,373	210,009,276	39%
UNITED EQUITABLE INS.	12,198,853	4,664,134	38%
LOYAL AMERICAN LIFE INS.	13,541,179	5,089,490	38%
CUMBERLAND LIFE INS. TENN.	27,900,013	10,333,959	37%
CONTINENTAL LIFE INS. TX	12,023,789	4,431,757	37%
BANNER LIFE INS.	17,300,135	6,374,875	37%
HERITAGE LIFE INS. CO.	12,052,051	4,376,167	36%
TRANSPORT LIFE INS. CO.	44,188,532	15,890,150	36%
FIREMANS FUND AMER. LIFE	82,669,574	29,659,755	36%

LYNDON INSURANCE CO.	34,467,324	12,839,777	38%
UNION NATL. LIFE INS. OF LA	16,621,736	5,740,988	35%
NORTH CENTRAL LIFE INS. CO.	19,083,200	6,089,407	32%
MIDLAND MUTUAL LIFE INS.	10,634,469	3,358,137	32%
PAUL REVERE PROT. LIFE	44,111,986	13,601,276	31%
FIDELITY SECURITY LIFE CO.	13,153,025	3,924,131	30%
AMERICAN INTEGRITY INS. CO.	11,954,742	3,548,255	30%
CENTRAL STATES INDEMNITY	14,198,432	3,922,616	28%
BERKSHIRE LIFE INS. CO.	12,400,729	3,255,781	26%
NRG. AMERICA LIFE REASSUR.	77,604,227	19,297,949	25%
GLOBE LIFE INS. CO.	26,189,900	6,070,707	23%
JMIC LIFE INS. CO.	10,478,972	1,988,264	19%
TRAVERLERS INDEMNITY	50,914,607	9,469,615	19%
CENTRAL NATL. INS. CO. - OMAHA	17,134,868	2,129,270	12%
LIFE ASSUR. CO. OF PA.	11,887,297	1,180,662	10%
PRUDENTIAL REINS. CO.	42,336,990	3,591,388	8%
AMERICAN WAY LIFE INS.	10,720,882	892,677	8%

APPENDIX E-3

PREMIUMS--CLAIMS--LOSS RATIO
ALPHABETICAL LISTING BY COMPANY NAME

COMPANY	PREMIUMS EARNED LESS DIVIDENDS (DOLLARS)	CLAIMS INCURRED (DOLLARS)	LOSS RATIO
ACADEMY LIFE INS. CO.	10,318,354	6,780,773	66%
AETNA CAS. & SUR. OF ILL.	93,562,947	100,936,284	108%
AETNA LIFE INS. & ANNUITY	29,794,025	16,821,256	56%
AETNA LIFE INS. CO.	1,957,669,157	1,390,371,505	71%
AETNA LIFE INS. CO. OF ILL.	52,042,203	47,459,270	91%
AID ASSN. FOR LUTHERANS-WI	55,074,403	36,134,188	66%
AIG LIFE INSURANCE CO.	49,113,954	27,413,047	56%
AIU INS. CO.	18,937,872	7,660,618	40%
ALEXANDER HAMILTON LIFE	125,979,895	91,855,814	73%
ALL AMERICAN LIFE	22,761,169	14,014,307	62%
ALLSTATE LIFE INS.	627,152,318	560,695,986	89%
AMALGAMATED LABOR LIFE	29,625,934	28,098,021	95%
AMER. FAMILY LIFE ASSUR.	664,070,240	270,273,609	41%
AMER. MANUFACTURERS MUT.	10,296,138	7,959,729	77%
AMERICAN BANKERS INS. CO.	11,256,691	6,995,852	62%
AMERICAN BANKERS LIFE FLA	48,867,410	22,390,935	46%
AMERICAN CASUALTY CO.	11,994,624	8,895,292	74%
AMERICAN CHAMBERS LIFE	50,413,893	33,948,184	67%
AMERICAN COMMUNITY MUTUAL	134,185,472	97,817,736	73%
AMERICAN FAMILY MUTUAL	114,478,978	73,224,831	64%
AMERICAN FIDELITY ASSUR.	92,901,576	62,662,038	67%
AMERICAN GENERAL LIFE DE.	16,926,090	10,879,695	64%
AMERICAN GENERAL LIFE TX.	34,774,213	31,920,211	92%
AMERICAN HARDWARE MUTUAL	31,736,486	26,752,199	84%
AMERICAN HERITAGE LIFE	62,738,995	45,725,069	73%
AMERICAN HLTH. & LIFE INS.	24,341,822	18,070,241	74%
AMERICAN HOME ASSUR. CO.	11,654,764	5,670,763	49%
AMERICAN INCOME LIFE INS.	25,773,413	13,764,297	53%
AMERICAN INDEPENDENT INS.	10,876,697	5,949,859	55%
AMERICAN INTEGRITY INS. CO.	11,954,742	3,548,255	30%
AMERICAN INTERNATL. LIFE	30,378,579	22,829,831	75%
AMERICAN LIFE & CAS. INS.	29,637,314	18,222,343	61%
AMERICAN LIFE INS. CO-DE	76,736,419	36,838,050	48%
AMERICAN MOTORISTS INS. CO.	42,887,284	32,553,447	76%
AMERICAN MUTUAL LIAB. INS.	12,568,497	12,277,928	98%
AMERICAN NATIONAL INSURANCE	60,156,922	42,785,364	71%
AMERICAN REPUBLIC INS. CO.	73,247,888	35,656,749	49%
AMERICAN ROAD INS.	22,191,484	12,851,344	58%
AMERICAN SECURITY LIFE	24,242,287	18,986,185	78%
AMERICAN SERVICE LIFE - TX	16,385,994	8,213,300	50%
AMERICAN STANDARD L & A	11,807,093	6,581,537	56%
AMERICAN STATES INS. CO.	33,485,678	21,005,566	63%
AMERICAN STATES LIFE INS.	25,559,161	23,423,198	92%
AMERICAN UNITED LIFE INS.	61,857,670	46,543,168	75%
AMERICAN WAY LIFE INS.	10,720,882	892,677	8%
APPLACHIAN NATL. LIFE INS.	19,696,617	13,488,030	68%
ARCADIA INSURANCE CO.	10,089,785	4,823,666	48%

ASSOCIATION LIFE INSURANCE CO.	44,302,851	29,639,255	67%
BANKERS LIFE & CASUALTY	502,961,365	369,080,173	73%
BANKERS LIFE OF NEB.	43,004,472	29,321,955	68%
BANKERS LIFE, IA.	804,810,831	590,624,012	73%
BANKERS MULTIPLE LINE INS.	30,854,283	18,068,252	59%
BANKERS UNITED LIFE ASSUR.	36,275,774	21,426,020	59%
BANNER LIFE INS.	17,300,135	6,374,875	37%
BCS LIFE INSURANCE CO.	49,041,092	42,549,609	87%
BENEFICIAL STANDARD LIFE	27,005,734	14,766,074	55%
BENEFIT TRUST LIFE INS. CO.	162,476,764	132,750,729	82%
BERKSHIRE LIFE INS. CO.	12,400,729	3,255,781	26%
BEST LIFE ASSUR. CO. CA	14,419,430	10,111,648	70%
BLC INSURANCE CO.	45,028,360	29,514,373	66%
BLUE ALLIANCE MUTUAL INS.	22,262,185	12,446,175	56%
BOSTON MUTUAL LIFE	18,888,679	11,555,992	61%
BUSINESS MENS ASSUR. CO.	118,128,989	86,533,160	73%
CAL-FARM LIFE	35,131,270	30,536,697	87%
CALIFORNIA LIFE INS. CO.	29,881,401	26,337,981	88%
CALIFORNIA PHYSICIANS INS.	24,956,634	19,172,281	77%
CALIFORNIA WESTERN STATES	50,859,051	65,841,872	129%
CAMPANION LIFE INS. - NY	23,523,983	16,618,672	71%
CANADA LIFE ASSUR. CO.	156,020,000	146,593,000	94%
CELTIC LIFE INS.-R I	23,880,306	15,763,907	66%
CENTENNIAL LIFE INS. CO.	26,190,298	16,944,678	65%
CENTRAL LIFE ASSURANCE CO.	64,847,502	45,931,256	71%
CENTRAL NATL. INS. CO. - OMAHA	17,134,868	2,129,270	12%
CENTRAL RESERVE LIFE-NA	51,434,767	29,468,332	57%
CENTRAL STATES HLTH & LIFE	54,897,581	27,185,984	50%
CENTRAL STATES INDEMNITY	14,198,432	3,922,616	28%
CERTIFIED LIFE INS. CO-CA	49,202,770	25,921,746	53%
COLOGNE LIFE REINS. CO.	40,900,159	30,456,941	74%
COLONIAL LIFE & ACCID. INS.	123,813,806	56,552,460	46%
COLONIAL LIFE INS. OF AMER.	104,258,169	82,636,364	79%
COLONIAL PENN. LIFE INS.	207,183,112	174,722,607	84%
COLUMBUS MUTUAL LIFE INS.	27,474,581	22,358,096	81%
COMBINED INS. CO. OF AMERICA	536,419,373	210,009,276	39%
COMBINED LIFE INS. CO-NY	29,717,535	11,826,089	40%
COMMERCIAL BANKERS LIFE	19,055,916	13,452,904	71%
COMMERCIAL LIFE INS. CO.	156,749,883	113,834,065	73%
COMMONWEALTH LIFE INS. - KY	21,412,722	14,214,250	66%
CONFEDERATION LIFE INS. CO.	412,072,000	395,960,000	96%
CONNECTICUT GENERAL LIFE	1,996,942,214	2,842,863,656	142%
CONNECTICUT MUTUAL LIFE	32,781,309	18,521,743	57%
CONNECTICUT NATIONAL	15,591,951	10,336,217	66%
CONSUMER BENEFIT LIFE	15,484,934	11,141,742	72%
CONTINENTAL AMER. LIFE INS.	22,796,027	10,730,870	47%
CONTINENTAL ASSUR. CO.	928,594,628	798,698,825	86%
CONTINENTAL CASUALTY CO.	111,327,238	82,561,020	74%
CONTINENTAL GENERAL INS.	17,756,872	7,911,476	45%
CONTINENTAL LIFE & ACCIDENT	41,784,132	33,454,585	80%
CONTINENTAL LIFE INS. TX	12,023,789	4,431,757	37%
COOPERANTS MUT. LIFE SOCY.	15,722,000	11,788,000	75%
COUNTRY LIFE INS. CO.	75,907,797	52,245,056	69%
CREDIT LIFE INSURANCE CO.	24,762,099	10,816,892	44%
CROWN LIFE INS. CO.	462,124,000	371,443,000	80%
CUDIS INS. SOCIETY INC.	125,786,925	75,904,358	60%

CUMBERLAND LIFE INS. TENN.	27,900,013	10,333,959	37%
CUNA MUTUAL INS. SOCIETY	54,560,029	38,219,547	70%
DEPENDABLE LIFE INS. CO. - FL.	17,133,126	13,241,052	77%
DOMINION LIFE ASSURANCE	43,092,000	39,938,000	93%
DURHAM LIFE INSURANCE CO.	90,557,309	63,319,933	70%
EAGLE LIFE INS. CO.	18,059,696	7,196,819	40%
EDUCATORS MUTUAL LIFE INS.	37,130,639	30,118,401	81%
EMPLOYERS REINS. CORP.	159,173,792	154,439,837	97%
EQUITABLE CAS. INS. CO.	50,565,091	57,542,085	114%
EQUITABLE LIFE & CAS. INS.	24,274,469	12,356,093	51%
EQUITABLE LIFE ASSUR. SOCY.	690,289,990	568,498,921	82%
EQUITY NATIONAL LIFE INS.	19,029,890	7,803,195	41%
EXECUTIVE FUND LIFE INS.	34,328,508	13,842,449	40%
FARMERS NEW WORLD LIFE CO.	30,348,638	24,920,444	82%
FARMLAND LIFE INS. CO.	20,165,347	14,393,236	71%
FEDERAL HOME LIFE INS. CO.	55,018,110	33,900,447	62%
FEDERATED MUTUAL INS. CO.	87,094,100	69,523,017	80%
FIDELITY SECURITY LIFE CO.	13,153,025	3,924,131	30%
FIREMANS FUND AMER. LIFE	82,669,574	29,659,755	36%
FIREMENS FUND EMPLOYERS	311,313,956	223,152,667	72%
FIRST CONTINENTAL L & A INS.	11,199,888	5,858,328	52%
FIRST DELAWARE LIFE	17,060,716	14,425,722	85%
FIRST HORIZON INS.	18,036,741	8,589,223	48%
FIRST NATIONAL LIFE - AL	12,595,025	8,919,333	71%
FOREMOST LIFE INS.	15,925,791	10,243,670	64%
FORUM INSURANCE CO.	10,501,509	5,912,237	56%
GENERAL AMERICAN LIFE INS.	318,109,594	263,463,324	83%
GENERAL REASSURANCE CORP.	38,057,515	21,919,150	58%
GEORGE WASHINGTON LIFE CO.	19,591,951	9,989,373	51%
GEORGIA CAS. & SUR. CO.	20,299,682	8,682,218	43%
GEORGIA INTERNATL LIFE CO.	32,847,626	24,911,290	76%
GERLING GLOBAL REINS. CORP.	10,359,204	8,652,105	84%
GLOBE LIFE & ACCIDENT INS.	81,304,107	43,477,748	53%
GLOBE LIFE INS. CO.	26,189,900	6,070,707	23%
GOLDEN RULE INSURANCE CO.	131,094,142	73,751,534	56%
GREAT AMERICAN RESERVE CO.	29,106,243	22,383,348	77%
GREAT REPUBLIC LIFE OF CA.	31,326,108	21,386,839	68%
GREAT SOUTHERN LIFE INS.	47,075,608	36,373,766	77%
GREAT-WEST LIFE ASSUR.	519,024,000	460,441,000	89%
GROUP LIFE & HEALTH INS.	60,085,854	58,534,396	97%
GUARANTEE MUTUAL LIFE CO.	27,248,471	21,875,557	80%
GUARANTEE TRUST LIFE INS.	44,128,284	30,631,133	69%
GUARDIAN LIFE OF AMERICA	539,946,089	417,975,453	77%
GULF LIFE GROUP INS. CO.	54,235,663	49,617,889	91%
GULF LIFE INSURANCE CO.	178,253,567	141,141,960	79%
HARBOR INSURANCE CO.	16,633,096	11,137,648	67%
HARTFORD LIFE & ACCIDENT	496,053,062	407,429,714	82%
HERITAGE LIFE INS. CO.	12,052,051	4,376,167	36%
HOME INS. CO.	14,684,608	9,408,031	64%
HOME LIFE INSURANCE CO.	142,780,666	116,789,755	82%
HOME SECURITY LIFE INS-NC	27,319,382	21,700,778	79%
HORACE MANN LIFE INS. CO.	61,268,187	45,985,519	75%
IDS LIFE INS. CO.	22,156,995	12,386,444	56%
ILLINOIS MUTUAL LIFE & CAS.	35,254,433	25,366,777	72%
IMPERIAL CAS. & INDEMN. CO.	11,104,674	4,548,758	41%
INA LIFE INSURANCE OF NY	39,295,522	29,110,986	74%

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MUTUAL PROTECTIVE INS. CO.	35,295,954	15,575,207	44%
MUTUAL SAVINGS LIFE INS.	12,717,679	5,408,379	43%
MUTUAL SECURITY LIFE INS.	87,198,309	52,033,072	60%
MUTUAL SERVICE LIFE INS.	38,444,527	28,926,901	75%
N. N. INVESTORS LIFE INS. CO.	155,993,635	101,259,221	65%
NATIONAL BENEFIT LIFE	41,242,553	25,535,068	62%
NATIONAL CASUALTY CO.	48,341,698	30,067,124	62%
NATIONAL FARMERS UNION	16,622,861	12,653,016	76%
NATIONAL FIRE INS.	29,129,798	21,602,853	74%
NATIONAL HOME LIFE ASSUR.	208,304,925	114,517,368	55%
NATIONAL LIBERTY LIFE INS.	23,808,583	12,975,015	54%
NATIONAL LIFE & ACCIDENT	95,882,234	55,936,457	58%
NATIONAL LIFE INS. CO., VT	22,534,475	13,593,432	60%
NATIONAL SAVINGS LIFE - TN	10,598,127	7,431,457	70%
NATIONAL STATES INS. CO.	25,626,852	11,558,308	45%
NATIONAL TRAVELERS LIFE	15,497,656	11,426,856	74%
NATIONWIDE MUTUAL FIRE	39,299,598	31,248,106	80%
NATIONWIDE MUTUAL INS. CO.	238,604,700	189,720,645	80%
NATL. HOME LIFE ASSUR. - NY	13,726,241	7,346,332	54%
NEW ENGLAND GEN. LIFE INS.	12,108,928	13,961,242	115%
NEW ENGLAND MUTUAL LIFE	226,941,447	162,553,841	72%
NEW YORK LIFE INS. CO.	863,753,678	573,572,579	66%
NORTH AMER. CO/L&H INS.	13,685,106	18,749,564	137%
NORTH AMER. LIFE & CAS. CO.	69,967,287	46,441,185	66%
NORTH AMERICAN REINS. CO.	41,530,415	40,920,511	99%
NORTH CAROLINA MUT. LIFE	13,391,539	10,669,725	80%
NORTH CENTRAL LIFE INS. CO.	19,083,200	6,089,407	32%
NORTHBROOK LIFE INS.	31,673,840	27,939,332	88%
NORTHWESTERN MUTUAL LIFE	81,136,147	38,225,661	47%
NORTHWESTERN NATL. LIFE	128,501,105	93,806,944	73%
NRG. AMERICA LIFE REASSUR.	77,604,227	19,297,949	25%
OHIO STATE LIFE INS. CO.	145,733,225	111,023,471	76%
OLD AMERICAN INS. CO.	18,300,907	8,546,542	47%
OLD SOUTHERN LIFE INS. CO.	11,640,231	6,135,845	53%
ORANGE STATE LIFE & HLTH.	19,275,443	12,691,089	66%
OXFORD LIFE INS. CO.	32,097,368	24,766,362	77%
PACIFIC HERITAGE ASSUR. CO.	18,877,546	12,502,620	66%
PACIFIC MUTUAL LIFE INS.	283,812,801	204,738,563	72%
PAN-AMERICAN LIFE INS. CO.	78,937,833	60,960,709	77%
PAUL REVERE LIFE INS. CO.	222,300,253	125,873,535	57%
PAUL REVERE PROT. LIFE	44,111,986	13,601,276	31%
PAULA INS. CO.	22,422,321	18,706,478	83%
PEERLESS INS. CO.	10,911,258	8,927,586	82%
PEKIN LIFE INS. CO.	19,125,395	11,897,802	62%
PENINSULAR LIFE INS. CO.	14,054,904	5,590,015	40%
PENNSYLVANIA LIFE INS. CO.	94,923,054	48,774,600	51%
PHF LIFE INSURANCE CO.	38,671,405	25,133,695	65%
PHILADELPHIA AMERICAN LIFE	44,439,114	39,385,768	89%
PHOENIX MUTUAL LIFE INS.	135,418,679	91,749,936	68%
PHYSICIANS MUTUAL INS. CO.	203,960,369	119,032,182	58%
PILOT LIFE INSURANCE CO.	343,620,698	279,700,231	81%
PIONEER LIFE INS. CO. OF IL.	31,520,933	16,936,461	54%
PROTECTIVE LIFE INS. CO.	63,605,474	49,013,300	77%
PROVIDENT ALLIANCE LIFE	42,863,764	23,647,906	55%
PROVIDENT GENERAL INS. CO.	12,186,135	15,734,670	129%
PROVIDENT INDEMNITY LIFE	13,853,752	8,718,911	63%

INDEPENDENT LIFE & ACCID.	122,698,529	62,776,057	51%
INS. CO. OF NORTH AMERICA	11,608,492	5,715,892	49%
INTER-OCEAN INS. CO.	43,296,579	24,768,062	57%
INTERCONTINENTAL LIFE - PR	19,526,098	14,499,958	74%
INTERCONTINENTAL LIFE INS.	14,910,224	8,002,686	54%
INTRAMERICA LIFE INS. CO.	14,755,061	13,819,958	94%
INVESTORS HERITAGE LIFE	11,347,089	7,787,039	69%
J. C. PENNEY LIFE INS. CO.	49,200,141	20,092,898	41%
JMIC LIFE INS. CO.	10,478,972	1,988,264	19%
JOHN ALDEN LIFE INS. CO.	156,713,543	94,532,751	60%
JOHN DEERE INS. CO.	29,681,215	28,629,747	96%
JOHN HANCOCK MUT. LIFE INS.	586,864,184	459,934,313	78%
KENTUCKY CENTRAL LIFE	17,827,141	11,027,365	62%
LAMAR LIFE INS. CO.	19,102,487	14,333,128	75%
LIBERTY LIFE ASSUR./BOSTON	18,821,353	16,579,960	88%
LIBERTY LIFE INSURANCE CO.	55,720,630	41,911,417	75%
LIBERTY MUT. FIRE INS. CO.	18,084,417	15,876,658	88%
LIBERTY MUTUAL INS. CO.	162,759,741	142,889,919	88%
LIBERTY NATIONAL LIFE INS.	109,390,251	58,772,930	54%
LIFE & CASUALTY OF TN.	34,318,430	21,528,455	63%
LIFE ASSUR. CO. OF PA.	11,887,297	1,180,662	10%
LIFE INS. CO OF NO. AMERICAN	333,735,648	238,670,267	72%
LIFE INS. CO. OF GEORGIA	80,425,387	59,098,800	73%
LIFE INS. CO. OF SOUTHWEST	14,341,498	10,634,593	74%
LIFE INS. CO. OF VIRGINIA	55,596,987	44,354,473	80%
LIFE INVESTORS INS/AMER	63,400,124	38,500,144	61%
LINCOLN NATIONAL LIFE INS.	904,287,298	674,843,359	75%
LONE STAR LIFE INS. CO.	77,726,097	49,524,862	64%
LOYAL AMERICAN LIFE INS.	13,541,179	5,089,490	38%
LUMBERMENS LIFE INS. CO.	22,981,394	16,065,654	70%
LUMBERMENS MUT. CAS. CO.	104,303,718	80,531,375	77%
LUTHERAN BROTHERHOOD	17,640,090	8,356,433	47%
LYNDON INS CO.	40,718,000	31,848,000	78%
LYNDON INSURANCE CO.	34,467,324	12,239,777	36%
MACCABEES MUTUAL LIFE	20,658,823	12,976,304	63%
MANUFACTURERS LIFE INS. CO.	24,733,000	22,395,000	91%
MASSACHUSETTS CAS. INS.	18,398,816	11,859,129	64%
MASSACHUSETTS IND. & LIFE	133,527,315	62,411,422	47%
MASSACHUSETTS MUTUAL LIFE	378,717,942	272,825,632	72%
MENNONITE MUTUAL AID ASSN.	28,828,031	23,393,567	81%
MERIT LIFE INS. CO.	28,521,550	13,178,947	46%
METROPOLITAN LIFE INS. CO.	1,462,106,272	982,140,216	67%
METROPOLITAN PROP. & LIAB.	43,500,430	89,262,889	205%
MIC LIFE INS. CORP.	10,409,129	5,901,638	57%
MICHIGAN LIFE INS. CO.	19,990,108	17,548,777	88%
MID-CONTINENT CASUALTY CO.	38,901,115	16,105,106	41%
MIDLAND MUTUAL LIFE INS.	10,634,469	3,358,137	32%
MINISTERS LIFE & MUTUAL	12,465,911	10,941,580	88%
MINNESOTA MUTUAL LIFE INS.	51,329,158	32,915,523	64%
MONARCH LIFE INS. CO.	60,964,578	38,946,556	64%
MONTGOMERY WARD LIFE INS.	64,871,263	29,078,027	45%
MONUMENTAL GENL. INS. CO.	18,709,626	10,069,065	54%
MONUMENTAL LIFE INS.	24,650,735	14,201,221	58%
MUTUAL BENEFIT LIFE INS.	382,154,253	288,466,753	75%
MUTUAL LIFE OF NEW YORK	252,466,444	181,704,425	72%
MUTUAL OF OMAHA INS. CO.	1,632,415,721	1,160,696,109	71%

PROVIDENT LIFE & ACCID. CO.	553,331,705	391,705,388	71%
PROVIDENT LIFE & CAS. INS.	33,118,357	21,284,306	64%
PROVIDENT MUTUAL LIFE INS.	116,514,445	84,611,437	73%
PRUDENTIAL INS. OF AMER.	2,702,628,771	2,099,725,986	78%
PRUDENTIAL PROP. & CAS. INS.	89,963,879	87,071,464	97%
PRUDENTIAL REINS. CO.	42,336,990	3,591,388	8%
PURITAN LIFE INSURANCE CO.	230,797,168	198,653,210	86%
PYRAMID LIFE INSURANCE CO.	37,177,325	23,414,540	63%
RELIANCE INSURANCE CO.	37,963,344	30,455,945	80%
RELIANCE STANDARD LIFE	52,742,095	41,683,363	79%
REPUBLIC NATL. LIFE GROUP	204,256,834	166,167,434	81%
RESERVE LIFE INSURANCE CO.	107,603,049	86,375,818	80%
RESERVE NATIONAL INS. CO.	32,665,795	15,864,809	49%
RURAL MUTUAL INS.	10,102,229	8,244,528	82%
RURAL SECURITY LIFE INS.	41,104,722	32,431,627	79%
SAFECO LIFE INSURANCE CO.	151,067,108	95,118,856	63%
SAVERS LIFE INS. OF AMER.	13,332,770	8,712,080	65%
SECURITY MUTUAL LIFE NY	10,721,919	7,971,778	74%
SECURITY MUTUAL LIFE, NE	11,482,174	10,545,745	92%
SECURITY OF AMER. LIFE INS.	20,415,038	12,336,451	60%
SENTRY INS. CO. A. MUTUAL	14,915,804	12,687,068	85%
SENTRY LIFE INSURANCE CO.	208,520,584	139,157,803	67%
SHELTER LIFE INS. CO.	64,574,668	43,829,193	68%
SIERRA GENERAL LIFE INS.	11,554,583	10,683,251	92%
SMA LIFE ASSUR. CO.	15,746,765	10,102,861	64%
SOUTHLAND LIFE INS. CO.	31,816,282	20,765,156	65%
SPRINGFIELD LIFE INS.	10,766,254	7,151,245	66%
ST. PAUL LIFE INS. CO.	72,151,279	51,532,157	71%
STANDARD INSURANCE CO.	98,981,206	85,976,440	87%
STANDARD LIFE & ACCID. INS.	48,678,888	31,206,258	64%
STATE FARM MUTUAL AUTO.	463,010,357	343,630,626	74%
STATE MUT. LIFE ASSUR. AMER.	238,855,974	165,507,324	69%
SUN LIFE ASSUR. CO. CANADA	268,918,000	277,262,000	103%
SWISS REINS. CO.	52,597,136	50,013,962	95%
SWISS-AM REASSURANCE CO.	61,455,759	76,261,865	124%
TEACHERS INS. & ANNUITY AM.	67,852,989	65,672,279	97%
TIME INSURANCE CO.	261,727,208	168,438,483	64%
TRANSAMER. OCCIDENTAL LIFE	677,325,719	589,344,891	87%
TRANSPORT LIFE INS. CO.	44,188,532	15,890,150	36%
TRAVELERS INDEM. OF RI.	116,064,999	91,124,969	79%
TRAVELERS INS. CO.	1,817,293,817	1,405,793,949	77%
TRAVELERS INS. CO. OF IL.	182,282,941	164,214,205	90%
TRAVERLERS INDEMNITY	50,914,607	9,469,615	19%
UNION BANKERS INS. CO.	68,866,507	37,703,158	55%
UNION CENTRAL LIFE INS. CO.	81,650,946	63,489,602	78%
UNION LABOR LIFE	155,591,654	130,467,539	84%
UNION LIFE INS. CO.	16,348,614	13,324,899	82%
UNION MUTUAL LIFE INS. CO.	101,324,628	79,927,962	79%
UNION NATL. LIFE INS. OF LA	16,621,736	5,740,988	35%
UNIONMUTUAL STOCK LIFE AM.	385,481,172	263,598,690	68%
UNIONMUTUAL STOCK LIFE NY.	67,694,690	49,293,195	73%
UNITED AMERICAN INS. CO.	216,629,860	94,736,773	44%
UNITED EQUITABLE INS.	12,198,853	4,664,134	38%
UNITED FARM BUR. FAM. LIFE	22,264,186	16,951,235	76%
UNITED FIDELITY LIFE INS.	18,225,785	13,422,878	74%
UNITED FOUNDERS LIFE - OK	10,838,264	6,884,699	64%

UNITED INS. CO. OF AMERICA	145,957,279	93,403,035	64%
UNITED LIFE & ACCIDENT	20,578,024	12,901,878	63%
UNITED STATES LIFE INS. CO.	128,022,102	99,633,207	78%
UNITED WISCONSIN INS. CO.	21,573,000	16,788,819	78%
VETERANS LIFE INS. CO.	11,527,676	6,353,360	55%
VULCAN LIFE INSURANCE CO.	44,137,209	35,235,210	80%
WABASH LIFE INS. CO.	11,316,909	6,626,654	59%
WASHINGTON NATIONAL INSURANCE	219,780,128	135,323,412	62%
WESTERN LIFE INSURANCE CO.	44,494,014	31,085,338	70%
WESTERN-SOUTHERN LIFE INS.	24,858,136	18,073,632	73%
WINTERTHUR SWISS INS. CO.	14,716,036	9,267,010	63%
WOODMEN ACCIDENT & LIFE	44,274,070	32,424,217	73%
WORLD INSURANCE CO.	24,734,991	14,883,396	60%
WORLD LIFE & HEALTH INS.	11,243,961	5,108,198	45%
WORLD SERVICE OF COLORADO	13,511,467	13,670,339	101%
ZALE LIFE INS. CO.	11,267,808	6,384,109	57%
ZURICH INS. CO.	28,799,180	17,295,700	60%

designed to work in combination with Medicare by paying...

- 100% of your Hospital Deductible
- 100% of Your Hospital Co-Payments
- 100% of all necessary hospital expenses for a lifetime maximum of 365 days after Medicare Part A hospital benefits stop completely
- Plus 20% of Medicare's allowable Doctor, Medical and Surgical expenses in or out of the hospital after you satisfy an annual $200 deductible
- Skilled Nursing Facility Benefits
- In-Hospital Private-Duty Nurse Care Benefits

	MEDICARE CURRENTLY DOES NOT PAY	THIS PLAN CURRENTLY PAYS
Hospital Costs during a benefit period: *(Medicare Part A)*		
Days 1-60	$492.00 Deductible	$492.00 Deductible
Days 61-90	$123.00 a day Co-Payment	$123.00 a day Co-Payment, for a maximum benefit of $3,690.00†
Days 91-150*	$246.00 a day Co-Payment	$246.00 a day Co-Payment, for a maximum benefit of $14,760.00†
Total For 150 Days	Unpaid $18,942.00†	Maximum Benefit Paid — $18,942.00†
After 150 Days*	Medicare Pays NOTHING	100% of necessary expenses for a lifetime maximum of 365 days.
Doctor, Medical & Surgical Bills: *(Medicare Part B)*	20% of all Medicare allowable charges...and the $75 annual Part B deductible	20% of all Medicare allowable charges after you satisfy an annual $200 deductible**... a maximum benefit of $100,000.00 per calendar year.
Skilled Nursing Facility Costs during a benefit period: *(Medicare Part A)*		
Days 1-20	Medicare Pays All Costs	—
Days 21-100	$61.50 a day Co-Payment	$61.50 a day
Days 101-300	No Medicare Coverage	$61.50 a day
In-Hospital Private Duty Nurse Care Costs.† Registered or Licensed Practical (Vocational) Nurse Care	No Medicare Coverage	$30.00 per 8-hour shift†

[redacted] Supplement II should not be purchased if you're eligible for Medicaid or if you already have a Medicare Supplement Insurance Plan. In addition, this plan may not be purchased if you already have a Medicare Supplement plan with Colonial Penn.

*After 90 days of hospitalization Medicare gives you an additional one-time-only Lifetime Reserve of 60 days of protection, which may be used for days 91 to 150. Remember, once you use that, Medicare Part A hospital benefits stop completely — BUT this supplemental protection picks up and pays 100% of your necessary hospital expenses for a lifetime maximum of 365 days.

**This annual calendar year deductible is satisfied by the first $200 of your Medicare-allowable charges not paid by Medicare.

†Up to 3 shifts per day for a maximum of 30 shifts during a Medicare benefit period. The care must be prescribed by your doctor or surgeon and you must be billed directly by the nurse, not the hospital.

Date Prepared	5-12-86
Releasing Officer	KCO

Notification To Medicare Insured:

Prepared for Medicare Cardholder:

Because of ever-increasing hospital costs, the Federal Government has again increased Medicare's Hospital Deductible and Co-Payments. That's the part of YOUR hospital charges Medicare leaves for you to pay.

As a result of this, if you are hospitalized in 1986, the following higher costs under Medicare Part A may be yours to pay completely...they are NOT paid by Medicare.

Your Higher Out-Of-Pocket Hospital Costs:

Days In-Hospital	1985 Deductible & Co-Payments	1986 Increase	1986 Costs You Have To Pay
Days 1 through 60	$ 400.00	$ 92.00	$ 492.00
Days 61 through 90	3,000.00	690.00	3,690.00
Days 91 through 150	12,000.00	2,760.00	14,760.00
NEW TOTAL OUT-OF-POCKET COSTS			$ 18,942.00

Immediate Action Recommended:

To protect against paying these higher out-of-pocket costs, it is recommended that you IMMEDIATELY consider adding Medicare Supplement II to your current Medicare insurance.

This added protection has been designed to work in combination with Medicare -- to help pay the costs Medicare does NOT pay...

Including all $18,942.00 listed above.

OVER, PLEASE

Supplemental coverage that works in combination with Medicare to help pay...

- ★ Hospital expenses
- ★ Doctor & Surgical expenses
- ★ Medical Care expenses
- ★ In-Hospital Private-Duty Nurse expenses
- ★ Skilled Nursing Facility expenses

...expenses NOT paid by Medicare!

DO NOT LOSE THIS CARD

Medicare Supplement

IDENTIFICATION CARD

Hospital and Medical Insurance

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Details Of Coverage, Plan A

Every honorably discharged U.S. Veteran has a right to cash benefits under this Hospital Insuranc

$75.00 a day
$2,250.00 a month
Heart Attack, Stroke, Cancer Benefits Under Age 65

You collect these increased cash benefits after the third day when hospitalization is the result of covered Heart Attack, Stroke or Cancer—even for life, if necessary!

$50.00 a day
$1,500.00 a month
Basic Cash Benefit Under Age 65

You collect these cash benefits for all other hospitalizations...from the very first day for every covered accident and after the third day for covered illnesses.

Benefits for ages 65 and over are paid in addition to Medicare.

Days Hospitalized	You collect for covered Heart Attack/Stroke/Cancer	You collect for all other covered Accidents/Illnesses
0-60	$37.50 a day	$25.00 a day
61-Lifetime	$75.00 a day	$50.00 a day

Benefits are paid the first day of hospitalization for accidents, and after the third day for illnesses.

In addition, this plan pays benefits for Nurse-At-Home Care, Accidental Loss Of Limbs/Sight, and DOUBLE Accident Indemnity—see Certificate of Coverage when it arrives for full details.

OPTIONAL COVERAGE includes: Children's and Maternity benefits. Indicate on Enrollment Form if coverage is desired.

The Exclusions Are:
Prior health conditions during the first two years of coverage. Loss due to act of war; mental disease or disorder; being under the influence of alcohol or narcotics. Pregnancy, unless Optional Maternity Benefits are chosen. (Complications of pregnancy are covered as any other illness.) Certain confinements or care in facilities, as defined in your Certificate, like nursing or convalescent. The first 3 days of hospitalization due to illness.

See LOW GROUP RATES on back ▶

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COMPANY
1986 MEDICARE SUPPLEMENT COVERAGE - POLICY FORM 911
OUTLINE OF COVERAGE

1. READ YOUR POLICY CAREFULLY. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract, and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is important that you READ YOUR POLICY CAREFULLY!
2. Medicare supplement coverage -- policies of this category are designed to supplement Medicare by covering some hospital, medical, and surgical services which are partially covered by Medicare. Coverage is provided for hospital in-patient charges and some physician charges, subject to any deductibles and co-payment provisions which may be in addition to those provided by Medicare and subject to other limitations which may be set forth in the policy. The policy does not provide benefits for custodial care such as help in walking, getting in and out of bed, eating, dressing, bathing, and taking medicine.
3. Neither Time nor its agents are connected with Medicare.
4. The following is a brief summary of the major benefit gaps in Medicare Parts A and B with a parallel description of supplemental benefits, including dollar amounts, provided by the Medicare supplement coverage.

Service - Part A	Benefit	Medicare Pays	This Policy Pays	You Pay
Hospitalization - includes Semiprivate room and board, general nursing, and miscellaneous hospital services and supplies: Meals, special care units, drugs, lab tests, diagnostic x-rays, medical supplies, operating and recovery room, anesthesia, and rehabilitation services.	First 60 days	All but $492	The $492 Deductible	Charges not eligible under Medicare
	61st to 90th day	All but $123 a day	$123 daily Deductible	Charges not eligible under Medicare
	90th day to 150th day	All but $246 a day	$246 daily Deductible	Charges not eligible under Medicare
	Beyond 150 days	Nothing	All Expense for Covered Services for Additional 365 Lifetime Maximum	All charges after 365 day Lifetime Maximum
Posthospital skilled nursing care in a facility approved by Medicare or a facility qualified for Medicare approval. You must have been in a hospital for at least 3 days and enter the facility within 30 days after discharge from the hospital.	First 20 days	100%	Nothing	Charges not eligible under Medicare
	Additional 80 days	All but $61.50	$61.50 per day	
	Beyond 100 days	Nothing	$61.50 per day for an additional 265 days	All charges less the daily amount paid by Time

Service - Part B	Benefit	Medicare Pays	This Policy Pays	You Pay
Medical Expenses	Physician's services, inpatient and outpatient medical services and supplies at a hospital, physical and speech therapy, and ambulance	80% of Medicare Approved Amount (after $75 deductible)	The $75.00 Deductible and 20% of Medicare Approved Amount, then 100% of Covered Expense* after the $_____ Calendar Year Deductible. +	Anything in excess of Medicare's & Time's payments

*Covered Expense: Means either 1) the amount charged for Medicare Part B covered service; or 2) an amount not to exceed 140% of the Medicare Approved Amount for that service, whichever is less.

+ A Calendar Year Deductible of $200.00 or $500.00 (you choose one) applies to Covered Expense which is in excess of Medicare Approved Amount. Please indicate your choice: ☐ $200.00; ☐ $500.00.

Form 17054 (Continued on Back)

Call 1-800

Understanding your Medicare coverage and how it works can be confusing. That's why we've installed a toll-free 800 number that gives you direct access to our Medicare Supplement Service Representatives. When you call, you'll deal with a highly trained specialist who knows the ins and outs of Medicare, as well as your Carefree Medicare Supplement policy. We're ready and willing to serve you.

How The Medicare Supplement Policy Pays

"Covered Services" and "Approved Amounts" For Each Benefit Period

Benefit		Medicare Pays	Pays	You Pay
Medicare Part A				
Hospital In-Patient	First 60 days	All but $492.00	The $492.00 deductible*	Nothing
	61st to 90th day	All but $123.00/day	The $123.00 daily deductible	Nothing
	91st to 150th day	All but $246.00/day	The $246.00 daily deductible	Nothing
	Beyond 150 days	Nothing	All eligible expenses for additional 365 day/ lifetime maximum	Nothing
Skilled Nursing	First 20 days	100%	Nothing	Nothing
	Additional 80 days	All but $61.50/day	$61.50 per day	Nothing
	Beyond 100 days	Nothing	$61.50 per day for an additional 265 days.	Any excess charges
Blood	First 3 pints of blood	Nothing	Full payment for first 3 pints of blood	Nothing
Medicare Part B				
Medical Expense	Physician in-hospital, home or office Out-patient hospital services	80% of Medicare's "Approved Amount" after a $75 deductible	The $75 deductible and 20% of Medicare's "Approved Amount" then 100% of "Covered Expenses"** after the $200 or $500 calendar year deductible.	Either a $200 or $500 deductible; you choose. Then, any portion of the charges in excess of 140% of the Medicare "Approved Amount".

You have no out-of-pocket expense up to Medicare's "Approved Amount".

*Coverage for the Medicare Part A deductible is optional in Georgia, Illinois and Mississippi.

**This means the expense which you incur for a Medicare Part B "Covered Service", not to exceed 140% of the Medicare "Approved Amount" for that service.

Benefit Period: A period that begins on the day you are admitted to a hospital and ends after a period of 60 consecutive days during which you were not confined in a hospital or Skilled Nursing Facility.

YOU PAY under Medicare Part A during each benefit period

- The Initial Hospital Deductible
- Extra cost of private room, unless medically necessary
- Cost of first 3 pints of blood
- Hospital Coinsurance for 61st through 90th day & 60 day Lifetime Reserve
- All hospital charges after all Medicare benefits run out
- Skilled Nursing Facility coinsurance for 21st through 100th day
- All Skilled Nursing Facility charges after the 100th day
- All charges in a Skilled Nursing Home not certified by Medicare
- All in-hospital Private Duty Nursing (R.N.) care charges

YOU PAY under Medicare Part B each year

- Medicare's calendar year deductible
- All Medicare coinsurance (the 20% Medicare does not pay) for medical and outpatient hospital expense amounts approved by Medicare
- All medical and outpatient hospital expense in excess of amounts approved by Medicare

YOUR MEDICARE provides these benefits during each benefit period

- The Initial Hospital Deductible 492 ==
- Extra cost of private room, if not paid by Medicare ... No Limit
- Cost of first 3 pints of blood
- Hospital Coinsurance for 61st through 90th day & 60 day Lifetime Reserve ... No Limit 123.00 A DAY
- All hospital charges ... No Limit 246 A DAY
- Medicare's Skilled Nursing Facility coinsurance for 21st through 100th day 61.50 A DAY
- Medicare's daily coinsurance amount from the 101st through 365th day 61.50 A DAY
- The Medicare Skilled Nursing Facility coinsurance amount for the 21st through 100th day of confinement 61.50 A DAY
- Up to $30 per 8-hour shift of Private Duty Nursing (R.N.) care — limit of 2 shifts a day for 90 days

YOUR MEDICARE provides these benefits each year

- None of the calendar year deductible. (Maryland: ☐ The calendar year deductible.)
- All Medicare coinsurance (the 20% Medicare does not pay) for medical and outpatient hospital expense amounts approved by Medicare ... No Limit
- Subject to the charges not exceeding 150% of the amounts approved by Medicare, will pay (after $200 of such excess in the calendar year) 80% of excess ... No Limit

LIMITATIONS AND EXCLUSIONS

[redacted]

EFFECTIVE DATE OF COVERAGE

[redacted]

MAKE CHECK PAYABLE TO COMPANY

Received of _____

the sum of $ _____ for _____ month's premium with application for Policy Form _____. If for any reason policy is not issued, payment is to be refunded in full. Insurance is not effective until policy applied for has been issued.

_____ Date

_____ Authorized Signature

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Keep This Page — Attach It to Your Policy

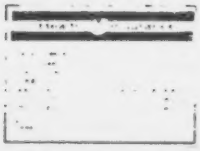
It highlights the benefits of your policy. It is not a contract. Your actual policy provisions (which may vary by state) will govern your benefits.

This card is the key to help pay what Medicare does NOT!

[redacted]

Everyone 65 or over needs this card

[redacted] **PAYS**



- ★ 100% of your initial in-hospital deductible when you choose [redacted]
- ★ 100% of your in-hospital co-payments
- ★ 100% of your Medicare allowable expenses for one full year after Medicare stops
- ★ 100% of your co-payments for Medicare allowable doctor, medical and surgical expenses—in or out of the hospital

Here are your [redacted] cash benefits

MEDICARE Part A Hospital Bills	MEDICARE Does Not Pay	[redacted] (the premium plan) Pays	[redacted] (the economy plan) Pays
Day 1 through 60	First $492.00	First $492.00 NOT paid by Medicare	$0
Days 61 through 90*	$123.00 EVERY Day	The $123.00 every day NOT paid by Medicare (Total: $3,690.00!)	The $123.00 every day NOT paid by Medicare (Total: $3,690.00!)
Days 91 through 150*	$246.00 EVERY Day	The $246.00 every day NOT paid by Medicare (Total: $14,760.00!)	The $246.00 every day NOT paid by Medicare (Total: $14,760.00!)
TOTAL at end of 150 days	$18,942.00!	The total $18,942.00 NOT paid by Medicare!	A total of $18,450.00 NOT paid by Medicare!
After 150 days	Medicare Stops Paying	100% of all Medicare allowable hospital bills for one full year after Medicare stops!	100% of all Medicare allowable hospital bills for one full year after Medicare stops!
Doctor, Medical, Surgical Bills (Medicare Part B)	20% of your Medicare allowable expenses—after you pay the first $75 each year	The 20% of your Medicare allowable expenses NOT paid by Medicare—up to $100,000 a year—after you pay the first $200 of such charges. (This includes Medicare's $75 expense requirement.)**	The 20% of your Medicare allowable expenses NOT paid by Medicare—up to $100,000 a year—after you pay the first $200 of such charges. (This includes Medicare's $75 expense requirement.)**
OPTION Skilled Nursing Facility (Medicare Part A) Day 1-20***	NOTHING UNPAID	———	———
Day 21-100	$61.50 EVERY Day	The $61.50 every day NOT paid by Medicare (Total: $4,920.00!)	The $61.50 every day NOT paid by Medicare (Total: $4,920.00!)

After 90 days of Hospitalization, Medicare give you a one-time lifetime reserve of 60 additional days of protection (Days 91-150). However, once this lifetime reserve of 60 days is exhausted, your [redacted] protection will begin paying 100% of your Medicare allowable bills the very day Medicare ends. And you'll have a lifetime number of a full 365 additional days (one year) of protection with [redacted].

**It's you pay any medical expenses not allowed by Medicare.

***Medicare pays 100%* of all reasonable costs the first 20 days of Posthospital Skilled Nursing Care in a facility approved by Medicare. You must have been hospitalized for at least 3 days and enter the facility within 30 days after hospital discharge.

Exclusions: Prior health conditions (those for which you received medical advice or treatment within the last six months) are not covered for the first six months... loss due to act of war... for care in a skilled nursing facility (if option is not selected)... limited benefits for mental disorders... or for services, facilities, and unreasonable expenses not covered by Medicare... You may have only one [redacted] Medicare Supplement Insurance Plan.

- [redacted] benefits are paid direct to you or to the doctor or hospital.
- Your protection can never be cancelled individually. As long as you continue your premiums and continue your Medicare coverages, and the master policy is not terminated, your protection cannot be terminated. Regardless of how much or how often you collect.
- [redacted] meets all federal standards for quality health insurance as outlined in Public Law 96-265.
- Your rate can increase only if rates increase for everyone in your class covered by Master Policy (NHC-1380-1083) or if your benefits are raised to match any changes in Medicare. You'll never be singled out for a rate increase, regardless of how much or how often you collect.
- Underwritten by [redacted] the insurance company nearly 2 million Americans depend on.

[redacted]

Any Questions? Call Toll-Free

[redacted]

Not affiliated with or endorsed by any Government or Medicare program.

Here's the Difference! L[illegible] Medicare Supplement Policy Helps YOU Pay Costs That Medicare Doesn't Cover for BOTH Parts A and B!!

EXPENSE INCURRED FOR	UNDER MEDICARE YOU PAY	MEDICARE PAYS	THIS MEDICARE SUPPLEMENT POLICY PAYS
Part A: HOSPITAL (EACH COVERED HOSPITALIZATION-SEMI-PRIVATE ROOM)			
First 60 Days	FIRST $492.00	BALANCE	FIRST $492.00
61st through 90th Day	$123.00 PER DAY	BALANCE	$123.00 PER DAY
91st to 150th Day if Lifetime Reserve Days	$246.00 PER DAY	BALANCE	$246.00 PER DAY
Upon exhaustion of Lifetime Reserve Days	ALL COSTS	NOTHING	90% of Medicare Eligible Expenses for up to an additional 365 days in your lifetime
BLOOD BENEFIT	FIRST 3 PINTS	ALL BUT FIRST 3 PINTS	FIRST 3 PINTS
SKILLED NURSING FACILITY (EACH COVERED PERIOD-FOST HOSPITAL)			
First 20 Days	Nothing	ALL	Nothing
21st through 100th Day	$61.50 PER DAY	BALANCE	$61.50 PER DAY
For each day after the 100th Day	ALL COSTS	NOTHING	$123.00 a day for up to an additional 365 days in your lifetime
Part B: OTHER MEDICAL EXPENSES (EACH CALENDAR YEAR) • Physician's and surgeon's services no matter where you receive them...at home, in the doctor's office, in a clinic or in a hospital. Routine physical exams are excluded. • Home health visits...Medicare pays the full costs of medically necessary home health visits. You have no deductible or co-payment. • Physical therapy and speech pathology services in a doctor's office or as an out-patient and on a limited basis, in your home. • Other medical services and supplies... such as outpatient hospital services; X-rays and laboratory tests; certain ambulance services; and purchase or rental of durable medical equipment, such as wheel chairs.	FIRST $75.00 EACH CALENDAR YEAR - PLUS 20% OF MEDICARE ELIGIBLE CHARGES OVER $75.00, PLUS ALL EXPENSES IN EXCESS OF REASONABLE AND NECESSARY CHARGES	80% OF REASONABLE CHARGES OVER $75.00 EACH CALENDAR YEAR (Medicare covers all medically necessary Home Health Care Visits 100% No Deductible.)	Benefits for Medicare Eligible Expenses over $75.00 at the Medicare Expense Percentage you select...your choice of a 20%, 30% or 40% Benefit for the remainder of the Calendar Year.

AMENDMENT RIDER 9834A

Treatment of mental, emotional or nervous disorders shall be provided to the Insured but shall be restricted to treatment as an in-patient in a mental hospital or general hospital and shall not exceed 30 days in any policy.

This rider shall include benefits for drug and alcohol rehabilitation and treatment, whether such care be provided in a mental or general hospital or other licensed alcoholic rehabilitation facility, necessary to restore any covered person to satisfactory emotional and physical health. Alcoholic and drug rehabilitation coverage is restricted to the reasonable cost of necessary services, and ninety days of active inpatient treatment in the Covered Person's lifetime.

Expenses incurred in a Municipal, County, State or Federal controlled or operated hospital are not covered if payment is not legally required in the absence of insurance.

Neither [illegible] Company nor its agents are connected with Medicare.

INDIVIDUAL MEDICARE SUPPLEMENT AND MEDICARE REPLACEMENT INSURANCE POLICIES

January 1, 1986 (Updated Semi Annually)
(Revised)

This list is prepared by the Insurance Commissioner's Office. It includes all individual Medicare supplement and Medicare replacement policies currently being sold in Wisconsin. Group policies such as those available through employers or associations are not included on this list.

All individual Medicare supplement policies sold in Wisconsin must fit into one of three categories. A Medicare supplement 1 is the most comprehensive. A Medicare supplement 3 is the least. A Medicare supplement 2 is in between. There is a separate category for Medicare replacements. Both Medicare supplements and Medicare replacements are explained in the booklet, "Health Insurance Advice for Senior Citizens."

Shopping around for insurance to supplement Medicare is a good idea. Check on premiums, waiting periods, and how selective the company is. This list is a good starting place. If you are interested in one of the policies on this list, contact the company directly or call a local agent for the company.

For more information call toll-free the MEDIGAP HOTLINE at 1-800-242-1060.

A booklet, "Health Insurance Advice for Senior Citizens" is available by sending a stamped, self-addressed envelope to:

Office of the Commissioner of Insurance
P.O. Box 7873
Madison WI 53707-7873

BE CAREFUL ABOUT REPLACING EXISTING POLICIES. THERE MAY BE NEW WAITING PERIODS OR OTHER RESTRICTIONS PLACED ON YOUR BENEFITS.

	1986 Annual Premium (subject to change)	Eligibility Standards*	Waiting Period** for Pre-existing Conditions	1st Year Commission to Agent	Brief Description of Benefits***: Medicare Part A	Medicare Part B
MEDICARE SUPPLEMENT 1 Bankers Life and Casualty Company 4444 West Lawrence Ave. Chicago IL 60630 Form No. CR-97F	Age: / Age: 65 $ 843.59 / 71 $1,174.46 66 890.07 / 72 1,124.23 67 940.57 / 73 1,311.15 68 933.81 / 74 1,384.35 69 1,050.97 / 75+ 1,472.93 70 1,111.19 Non-Smokers discount available. Additional benefits available at additional cost.	No health questions asked	60 days	26% to age 75 13% after age 75	*Hospital* - After initial deductible, policy pays co-insurance. After 100 days, pays 100% *Skilled Nursing Facility* Co-insurance to 100th day. 100% of charges to 365 days, $50.00 per day for another 100 days	*Medical* - After $75 deductible, policy pays difference between Medicare's payment and the usual and customary charges as determined by the company to $10,000 per year. *Other benefits* - 75% of the usual and customary expense for prescription drugs; subject to the $10,000 per year Medicare Part B coverage limit

1986 Annual Premium (subject to change)	Eligibility Standards*	Waiting Period** for Pre-existing Conditions	1st Year Commission to Agent	Brief Description of Benefits*** Medicare Part A	Medicare Part B
MEDICARE SUPPLEMENT 2					
Aid Association for Lutherans 4321 North Ballard Road Appleton WI 54919 Form No. 4717WI Area (first 3 digits of zip code) Male Female 530, 531, 534 $699.29 $667.11 532 710.56 678.27 535, 546, 549, 680.49 648.51 537, 539, 544, 545 661.68 629.91 538, 540, 543, 547, 548 635.36 603.87	Health questions asked Available only to Lutherans	6 months	15%	*Hospital* - Policy pays full deductible and co-insurance. After 150 days, pays 100% *Skilled Nursing Facility* Co-insurance to 100th day. 100% of charges to 365th day	*Medical* - After $75 deductible, policy pays 25% of charges incurred. *Other benefits* - Pays 100% of prescription drugs and 80% of private duty nursing expenses after $60 annual deductible
American Family Mutual Ins. Co. 3099 East Washington Avenue P.O. Box 7430 Madison WI 53783 Form No. H-65 All Zip Codes except Madison and Milwaukee: Male $446.50, Female $404.70 Madison and Milwaukee: Male $470.00, Female $426.00 Age 65: $446.50 / $404.70 / $470.00 / $426.00 70: 499.70 / 449.40 / 526.00 / 473.00 75: 588.10 / 526.30 / 619.00 / 554.00 80: 687.80 / 609.90 / 724.00 / 642.00 85: 768.60 / 700.20 / 809.00 / 737.00 This is a summary of premiums. There is a different premium for each age.	Health questions asked	6 months	18.75%	*Hospital* - Policy pays full deductible and co-insurance. After 150 days, pays all eligible expenses to 365 days *Skilled Nursing Facility* Co-insurance to 100th day 100% to 365th day	*Medical* - Policy pays $75 deductible if you are hospitalized plus 20% Medicare approved charges
American Republic Insurance Company P. O. Box 1 Des Moines IA 50334 Form No. A-2400WI 5-85 Age: 65-69 $447.18; 70-74 505.74; 75-80 567.74 Additional benefits available at additional cost	Health questions asked	6 months	40% —	*Hospital* - Policy pays full deductible and co-insurance. After 150 days, pays all eligible expenses to 365 days lifetime maximum. *Skilled Nursing Facility* Co-insurance to 100th day 100% to 365 days per benefit period	*Medical* - After $75 deductible, policy pays 20% of Medicare-approved charges up to $100,000.

MEDICARE SUPPLEMENT 2	1986 Annual Premium (subject to change)	Eligibility Standards*	Waiting Period** for Pre-existing Conditions	1st Year Commission to Agent	Brief Description of Benefits*** Medicare Part A	Medicare Part B
Benefit Trust Life 1771 Howard Street Chicago IL 60626 Form No. MSW182	Age: 65 $ 667.23 66-69 765.35 70-74 913.43 75-79 1,098.99 80-84 1,323.78 85+ 1,578.88	General questions on confinement in hospital or other facility, current treatment for cancer, kidney, dialysis and mental illness	45 days	45% average	*Hospital* - Policy pays full deductible and co-insurance. After 150 days, pays up to 525th day *Skilled Nursing Facility* Co-insurance to 100th day. Usual and customary charges to 365th day	*Medical* - After $75 deductible, policy pays 20% of usual and customary charges up to $100,000 per year *Other benefits* - 80% of prescription drug charges after hospital confinement and 80% of private duty nursing charges for 14 days in hospital and 14 days following hospital confinement
Blue Cross & Blue Shield United of Wisconsin 401 W. Michigan Street Milwaukee WI 53202 Form No. X-1425a	$479.40 (same for everybody)	General questions on confinement in hospital or other facility and ability to perform normal activities	6 months	10%	*Hospital* - Policy pays full deductible and co-insurance. After 150 days, pays next 365 in full *Skilled Nursing Facility* Co-insurance to 100th day. 100% to 365 days	*Medical* - Policy pays $75 and 20% of Medicare-approved charges up to $5,000
					After $500 out-of-pocket, pays up to $250,000 for Major Medical hospital, medical expense and prescription drug benefits.	
Central States Health & Life Co. of Omaha 96th and Western Omaha NE 68134 Form No. 286 WI Rev. Additional benefits available at additional cost.	Age: 65-69 $408.00 70-74 474.00 75+ 576.00	Health questions asked	None	40%	*Hospital* - After initial deductible, policy pays co-insurance to 150th day. After 150 days pays up to 365 days *Skilled Nursing Facility* Co-insurance to 100th day. 100% to 365 days	*Medical* - After $75 deductible, policy pays 20% of usual and customary charges as determined by the company

MEDICARE SUPPLEMENT 2	1986 Annual Premium (subject to change)	Eligibility Standards*	Waiting Period** for Pre-existing Conditions	1st Year Commission to Agent	Brief Description of Benefits*** Medicare Part A	Medicare Part B
Compcare Health Services Insurance Corp.* 401 West Michigan Street Milwaukee WI 53201 Form No. PGP-660 Available in Racine and Burlington areas only	$691.80 for everybody	Health questions asked	None	Independent agent -- 10% Company agent -- $.50 per month for duration of policy	*Hospital* - After initial deductible, policy pays co-insurance. After 150 days, policy pays for unlimited number of days *Skilled Nursing Facility* Co-insurance to 100th day 100% to 365 days per benefit period	*Medical* - After $75 deductible, policy pays 20% of Medicare-approved charges and 20% of usual and customary charges for non-Medicare covered charges as determined by the company.
Compcare Health Services Insurance Corp.* 401 West Michigan Milwaukee WI 53201 Form No. PGP-661 Available in Racine and Burlington areas only	$598.20 for everybody	No health questions asked	None	Independent agent -- 10% Company agent -- $.50 per insured per month for duration of policy	*Hospital* - After initial deductible, policy pays co-insurance to 150th day. 100% for unlimited number of days *Skilled Nursing Facility* Co-insurance to 100th day After 100th day, pays additional benefits for 265 days	*Medical* - After initial deductible, policy pays 20% of Medicare-approved charges and 20% of usual and customary charges for non-Medicare covered charges as determined by the company
Continental Casualty Company CNA Plaza Chicago IL 60685 Form No.. P1-67720-B48 Additional benefits available at additional cost.	Male / Female Age: 65-69: $ 596.27 / $ 533.17 70-74: 741.49 / 637.92 75-79: 914.07 / 785.07 80-84: 1,045.34 / 923.50 85+: 1,216.17 / 1,073.03	General questions on confinement in hospital, skilled nursing facility or rehabilitation facility in last 60 days	5 months	42% average	*Hospital* - Policy pays full deductible and co-insurance. After 150 days, pays next 365 in full *Skilled Nursing Facility* Co-insurance to 100th day. 100% to 365 days	*Medical* - Policy pays $75 deductible and 20% or 40% of Medicare-approved charges

*This is a Medicare supplement health maintenance organization. Full benefits generally are paid only if services are received from participating providers in the geographical area served by the plan.

1986 Annual Premium (subject to change)	Eligibility Standards*	Waiting Period** for Pre-existing Conditions	1st Year Commission to Agent	Brief Description of Benefits***	
MEDICARE SUPPLEMENT 2				Medicare Part A	Medicare Part B
Continental General Insurance Company 8901 Indian Hills Drive Omaha NE 68114 Form 318 Age: 65 $419.40 70 505.00 75 598.50 80 683.50 85+ 798.30 Additional benefits available at additional cost.	Limited health questions asked	60 days	60%	*Hospital* - After initial deductible, policy pays co-insurance. After 150th day, pays 100% to 365 days. Rider to cover initial deductible available at additional cost *Skilled Nursing Facility* Co-insurance to 100th day. 100% to 365 days per benefit period	*Medical* - Policy pays $75 deductible and 20% of usual and customary charges as determined by the company *Other Benefits* - Policy pays initial Part A deductible. Policy pays 40% usual and customary charges of Part B benefits (Policy pays nothing for the Part B initial deductible and hospital indemnity benefits)
Dean Health Plan, Inc.* $438 1313 Fish Hatchery Road (for everybody) Madison WI 53715 Form No. 1059-0484 Available in Columbia, Dane, Dodge, Fond du Lac, Green, Green Lake, Iowa, Jefferson, Juneau, Lafayette, Marquette, Richland, Rock, Sauk and Walworth counties only	No health questions asked	None	None-agents are salaried	*Hospital* - Policy pays initial deductible, and co-insurance to 150th day. 100% after 150th day *Skilled Nursing Facility* Co-insurance to 100th day. 100% after	*Medical* - Policy pays $75 deductible and 20% of Medicare-approved charges.
Federal Life Insurance Company 3750 West Deerfield Road Riverwoods IL 60015 A-7400 WISC Age: 65-69 $281.49 70-74 321.45 75-79 344.99 80-84 359.07 85+ 372.95 Additional benefits available at additional cost	Limited health questions asked	6 months	40%	*Hospital* - Policy pays full deductible and co-insurance. After 150 days, pays next 365 days in full. Rider to cover initial deductible available at additional cost *Skilled Nursing Facility* Co-insurance to 100th day 100% to 365 days	*Medical* - Policy pays $75 deductible and 20% of Medicare-approved charges up to $20,000

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MEDICARE SUPPLEMENT 2	1986 Annual Premium (subject to change)	Eligibility Standards*	Waiting Period** for Pre-existing Conditions	1st Year Commission to Agent	Brief Description of Benefits*** Medicare Part A	Medicare Part B
Federal Home Life Insurance Company 78 West Michigan Mall Battle Creek MI 49017 Form No. 4535(S) WI 20% Option Age: 65-69 Male $ 672.69 Female $ 584.25 70-74 785.77 685.89 75-79 904.57 809.53 80-84 1,051.09 962.21 85+ 1,188.37 1,095.97 Additional benefits available at additional cost	Health questions asked	6 months	50%	*Hospital* - Policy pays initial deductible and co-insurance to 150th day. After 150 days, pays next 365 days in full *Skilled Nursing Facility* Co-insurance to 100th day. 100% to 365 days	*Medical* - After you pay $75 deductible, policy pays 20% of usual and customary charges as determined by the company
Greater Marshfield Community* $630.00 Health Plan Blue Cross & Blue Shield United of WI 401 W. Michigan Street Milwaukee WI 53202 Form No. PGP-631 Available in Barron, Chippewa, Clark, Eau Claire, Jackson, Marathon, Price, Rusk, Taylor, Washburn and Wood Counties	None - Must live in Greater Marshfield area 9 months per year. Enrollment at age 65 only	None	3%	*Hospital* - Policy pays deductible and co-insurance and unlimited hospital days *Skilled Nursing Facility* Co-insurance to 100th day. 100% for unlimited days if needed for treatment and requested by doctor	*Medical* - Policy pays $75 deductible and 20% of usual and customary charges as determined by the company.
Group Health Cooperative of Eau Claire* 1010 West Clairemont Avenue Eau Claire WI 54701 Form No. 5000 Age: 65-74 $300 75+ 420 Note: Only Quarterly Premiums Accepted Additional benefits available at additional cost	Health questions asked	None	None - there are no agents	*Hospital* - Policy pays deductible, and co-insurance. After 150 days, pays 100% to 365 days lifetime maximum *Skilled Nursing Facility* Co-insurance to 100th day 100% to 365 days	*Medical* - Policy pays $75 deductible, and 100% of difference between Medicare-approved and actual charges

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MEDICARE SUPPLEMENT 2	1986 Annual Premium (subject to change)	Eligibility Standards*	Waiting Period** for Pre-existing Conditions	1st Year Commission to Agent	Brief Description of Benefits*** Medicare Part A	Medicare Part B
Guarantee Trust Life Ins. Co. 2537 W. Montrose Avenue Chicago IL 60618 Form No. 23916-2	Age: 65-69 $ 739.30 70-74 816.32 75-79 894.10 80-84 963.50 85+ 1,042.92	Health questions asked	6 months	60%	*Hospital* - After initial deductible, policy pays co-insurance to 150th day. After 150th day, pays 100% to 365 day lifetime maximum. Rider to cover initial deductible available at additional cost *Skilled Nursing Facility* Co-insurance to 100th day. 100% of Medicare allowable charges to 365th day.	*Medical* - Policy pays $75 deductible and 20% of Medicare-approved charges.
HMO of Wisconsin* 180 Washington Street Prairie du Sac WI 53578 Form No. 12-040-0285 Available in Columbia, Dane, Green, Jefferson, Rock and Sauk Counties only	$483.84 (For everybody)	Health questions asked	None	None	*Hospital* - Policy pays full deductible and co-insurance. After 150 days, pays 100% up to 365 days *Skilled Nursing Facility* Co-insurance to 100th day. 100% to maximum of 365 days per benefit period	*Medical* - Policy pays $75 deductible and 20% of usual and customary charges up to $5,000 per year.
Jackson Health Plan* 345 West Washington Avenue Madison WI 53703 Form No. XXX-291 Available in Columbia, Dane, Green, Jefferson, Rock and Sauk Counties only	Age: 65-69 $356.64 70-74 409.56 75-79 491.16 80+ 568.08	Health questions asked	None	None	*Hospital* - Policy pays full deductible and co-insurance. After 150 days, pays 100% up to a maximum of 365 days in a lifetime *Skilled Nursing Facility* Co-insurance to 100th day. 100% to 365 days	*Medical* - Policy pays $75 deductible and 100% of remaining charges for services provided by plan providers.

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MEDICARE SUPPLEMENT 2	1986 Annual Premium (subject to change)	Eligibility Standards*	Waiting Period** for Pre-existing Conditions	1st Year Commission to Agent	Brief Description of Benefits*** Medicare Part A	Medicare Part B
Medical Associates Clinic Health Plan of Wisconsin* One Dubuque Plaza Dubuque IA 52001 Form No. Med-Con. Wi.	$468.00 for everybody Available in Crawford and Grant Counties	No health questions asked	None	None	*Hospital* - After initial deductible, policy pays co-insurance. After 150th day, pays 100% *Skilled Nursing Facility* Co-insurance to 100th day 100% after 100th day	*Medical* - After $75 deductible, policy pays 100% of difference between Medicare-approved and actual charges. *Other Benefits* - 50% of out-of-hospital psychiatric coverage per calendar year
Medico Life Insurance Company/ Mutual Protective Insurance Company 4625 Farnam Street Omaha NE 68132 Form No. ML485ZL/MP 48ZL	Age: 64 1/2-69 $ 699.60 70-74 832.00 75-79 872.95 80 & over 1,047.25 Additional benefits available at additional costs	Health questions asked	6 months	55%	*Hospital* - After intitial deductible, policy pays co-insurance to 150th day. After 150 days, 100% of Medicare allowable charges to 365th day *Skilled Nursing Facility* Co-insurance to 100th day 100% to 365 days per benefit period	*Medical* - After initial deductible, policy pays 20% of Medicare-approved charges up to $20,000 in a calendar year
MidAmerica Mutual Life Hennepin Square 2021 E. Hennepin Avenue Minneapolis MN 55413 Form No. U-1086WI	Age: 65-69 $444.00 70-74 449.50 75 & older 555.00	Health questions asked	6 months	25%	*Hospital* - Policy pays full deductible and co-insurance. After 150 days, pays 100% of costs to lifetime maximum of 365 days *Skilled Nursing Facility* Co-insurance to 100th day. An additional 265 days per benefit period paying 100% of the cost	*Medical* - Policy pays $75 deductible and 20% of Medicare approved charges up to $5,000 each calendar year

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1986 Annual Premium (subject to change)	Eligibility Standards*	Waiting Period** for Pre-existing Conditions	1st Year Commission to Agent	Brief Description of Benefits*** Medicare Part A	Medicare Part B
MEDICARE SUPPLEMENT 2					
Midelfort Clinic* 1119 Regis Court Eau Claire WI 54701 Form No. XXX-291 Age: 65-69 $432.00; 70-74 496.80; 75-79 595.20; 80+ 688.20 Available in Barron, Buffalo, Chippewa, Dunn, Eau Claire, Pierce, Pepin, Polk, Rusk, St. Croix, Trempealeau and Washburn Counties only	Health questions asked	None	None	*Hospital* - Policy pays full deductible and co-insurance. After 150 days, pays 100% up to a maximum of 365 days in a lifetime *Skilled Nursing Facility* Co-insurance to 100th day. 100% to 365 days	*Medical* - Policy pays $75 deductible and 100% of remaining charges.
Mutual of Omaha Mutual of Omaha Plaza Omaha NE 68175 Form No. M40 Age: 65-69 $490.68; 70-74 604.32; 75-79 662.28; 80+ 726.48	Health questions asked	6 months on ridered conditions	37%	*Hospital* - Policy pays full deductible and co-insurance. After 150 days, pays 100% up to 365 days in a lifetime *Skilled Nursing Facility Approved by Medicare* Co-insurance to 100th day. 100% to 365 days *Skilled Nursing Facility Not Approved by Medicare* Policy pays 100 days at the daily rate established for such skilled nursing home by the Wisconsin Department of Health and Social Services	*Medical* - After you pay $75 deductible, policy pays 30% of Medicare-approved charges. $75 deductible paid if hospital-confined

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1986 Annual Premium (subject to change)	Eligibility Standards*	Waiting Period** for Pre-existing Conditions	1st Year Commission to Agent	Brief Description of Benefits*** Medicare Part A	Medicare Part B
MEDICARE SUPPLEMENT 2					
National States Ins. Co. 11433 Olde Cabin Rd. St. Louis MO 63141 Age: Form No. SMW-2 to 70 $554.00 71-75 641.00 76+ 735.00 Additional benefits available at additional cost	Health questions asked	6 months	60%	*Hospital* - Policy pays full deductible and co-insurance. After 15 days, pays 100% of expenses for next 365 days *Skilled Nursing Facility* Co-insurance to 100th day - 100% to 365th day	*Medical* - Policy pays $75 deductible and 20% of Medicare-approved charges up to $5,000 maximum per calendar year
Pekin Life 2505 Court Street Pekin IL 61558 Age: Form No. H15 (W) 65-69 $258.20 70-74 300.42 75-79 347.31 80-84 387.77 85+ 427.18 Additional benefits available at additional cost	Limited health questions asked	6 months	20%	*Hospital* - After initial deductible, policy pays co-insurance. After 150 days policy pays 100% of Medicare-eligible expenses to 365 days *Skilled Nursing Facility* Co-insurance to 100th day. 100% Medicare-eligible expenses to 365 days	*Medical* - After you pay $75 deductible, policy pays 20% of Medicare-approved charges
Physicians Mutual Insurance Company 20% 115 S. 42nd Street Age: 65-69 $486.43 Omaha NE 68131 70-79 614.61 Form No. P192K-0783 80-89 785.12 Additional benefits available at additional cost	A general question on confinement in hospital or nursing home in past 90 days	None	20%	*Hospital* - Policy pays full deductible and co-insurance. After 150 days, pays next 365 in full *Skilled Nursing Facility* Co-insurance to 100th day. 100% to 365 days	*Medical* - After $60 deductible, policy pays 20% or 40% of actual charge if Medicare pays part of that charge
Rural Security Life Insurance Company 7010 Mineral Point Road Madison WI 53705 Form No. HP-112 (7-82) Male $763.11 Female 566.21	Health questions asked	None	8%	*Hospital* - Policy pays full deductible and co-insurance. After 150 days, pays next 365 in full *Skilled Nursing Facility* Co-insurance to 100th day. 100% to 365 days.	*Medical* - Policy pays $75 deductible and all eligible expenses not paid by Medicare to maximum of $10,000. Not limited to Medicare's approved charge

MEDICARE SUPPLEMENT 2	1986 Annual Premium (subject to change)	Eligibility Standards*	Waiting Period** for Pre-existing Conditions	1st Year Commission to Agent	Brief Description of Benefits*** Medicare Part A	Medicare Part B
State Farm Mutual Automobile Ins. Co. One State Farm Plaza Bloomington IL 61701 Form No. 97033MA Available to people under age 65 who are on Medicare because of a disability and are converting from company's hospital-surgical policy	Age: 0-64 $572.30 65-69 360.90 70-74 449.70 75+ 540.40	No health questions asked	6 months	17%	*Hospital* - Policy pays full deductible and co-insurance. After 150 days, pays Medicare-approved expenses up to 365 days. *Skilled Nursing Facility* Co-insurance to 100th day. After 100 days, eligible expenses to extent not covered by Medicare to 365 day maximum	*Medical* - Policy pays $75 deductible and 20% of Medicare-approved charges, up to $5,000 per year
Time Insurance Company 515 West Wells Street Milwaukee WI 53201 Form No. 913 Additional benefits available at additional cost	Age: Male / Female 65-69 $742.00 / $714.00 70-74 822.00 / 799.00 75-79 879.00 / 856.00 80-84 907.00 / 896.00 85+ 919.00 / 921.00	Health questions asked	6 months	30%	*Hospital* - Policy pays full deductible and co-insurance. After 150 days, pays next 265 in full *Skilled Nursing Facility* Co-insurance to 100th day. 100% to 365 days	*Medical* - After you pay $75 deductible, policy pays 20% of Medicare-approved charge. After either $200 or $500 of eligible expenses in excess of approved amount, policy pays 100% up to 140% of Medicare
Wisconsin Physicians Service 1717 West Broadway Madison WI 53708 Form No. 13789-B51-8207	$369.00 (same for everybody)	Open enrollment at age 65; health questions asked at other times	6 months	15%	*Hospital* - Policy pays full deductible and co-insurance. After 150 days, pays all hospitalization in full *Skilled Nursing Facility* Co-insurance to 100th day. 100% after 100th day	*Medical* - Policy pays $75 deductible and 20% of Medicare-approved charges up to $5,000 per year

MEDICARE SUPPLEMENT 3	1986 Annual Premium (subject to change)	Eligibility Standards*	Waiting Period** for Pre-existing Conditions	1st Year Commission to Agent	Brief Description of Benefits*** Medicare Part A	Medicare Part B
American Income Life Ins. Co. P.O. Box 208 Waco TX 76797 Form No. H41004	Age: 65-69 $563.00; 70-74 625.00; 75-79 683.00; 80-84 720.00; 85+ 732.00	Health questions asked	6 months	50%	*Hospital* - Policy pays full deductible and co-insurance. After 150 days, pays 90% to 365 days *Skilled Nursing Facility* Co-insurance to 100th day	*Medical* - Policy pays $75 deductible and 20% of Medicare-approved charges
Bankers Life and Casualty Co. 4444 Lawrence Avenue Chicago IL 60630 Form No. GR-75R Age: 65 $354.76; 66 371.02; 67 389.78; 68 410.29; 69 432.65; 70 456.76; Age: 71 $482.72; 72 510.43; 73 540.10; 74 571.52; 75 605.12 Lower rates for non-smokers. Additional benefits available at additional cost		No health questions asked	60 days	26% to age 75 13% after age 75	*Hospital* - After initial deductible, policy pays full deductible and co-insurance. After 150 days, pays 100% of usual and customary expenses. *Skilled Nursing Facility* Nothing	*Medical* - After you pay $75 deductible, policy pays 20% of Medicare-approved charges up to $5,000 maximum each year
Bankers Life and Casualty Co. 4444 Lawrence Avenue Chicago IL 60630 Form No. GR-75D (1982)	Age: 65-69 $646.90; 70-74 689.45; 75+ 774.54	No health questions asked	60 days	25%	*Hospital* - Policy pays full deductible and co-insurance. After 150 days, pays 100% of usual and customary expenses. *Skilled Nursing Facility* Co-insurance to 100th day	*Medical* - After you pay $75 deductible, policy pays 20% of Medicare-approved charges up to a $5,000 maximum each calendar year
Benefit Trust Life 1771 W. Howard Street Chicago IL 60626 Form No. MSP 182 WI	Age: 65 $ 606.58; 66-69 695.77; 70-74 829.59; 75-79 999.07; 80-84 1,204.25; 85+ 1,436.17	Health questions on confinement in hospital or other facility, current treatment for cancer, kidney dialysis and mental illness	45 days	45% average	*Hospital* - Policy pays full deductible and co-insurance. After 150 days, pays 90% up to 525th day *Skilled Nursing Facility* Co-insurance to 100th day. 80% of usual and customary up to 180th day	*Medical* - After you pay $75 deductible, policy pays 20% of usual and customary charges up to $100,000 per year. *Other benefits* - 80% of prescription drug charges after hospital confinement and 80% of private duty nursing charges for 14 days in hospital and 14 days after hospital confinement

1986 Annual Premium (subject to change)	Eligibility Standards*	Waiting Period** for Pre-existing Conditions	1st Year Commission to Agent	Brief Description of Benefits*** Medicare Part A	Medicare Part B
MEDICARE SUPPLEMENT 3					
Globe Life and Accident Insurance Company Globe Life Center Oklahoma City OK 73184 Form No. MCP-3MWI Age: 65-70 $563.00 71-75 652.00 76-85 744.00 86-90 835.00 Additional benefits available at additional cost	Health questions asked	6 months	40%	*Hospital* - Policy pays full deductible and co-insurance. After 150 days, pays 100 to 365 days *Skilled Nursing Facility* Co-insurance to 100th day. Nothing after that	*Medical* - After you pay $75 deductible, policy pays either 20% or 32% of Medicare-approved charges
Guarantee Trust Life Ins. Co. 2537 W. Montrose Avenue Chicago IL 60618 Age: Form No. 80335-3C 65-69 $323.20 70-74 351.90 75-79 375.60 80-84 393.40 85+ 416.20 Additional benefits available at additional cost	Health questions asked	6 months	60%	*Hospital* - After initial deductible, policy pays full deductible and co-insurance. After 150 days, pays next 365 days at 90% *Skilled Nursing Facility* Nothing	*Medical* - After $200 deductible, policy pays 20% of the remaining eligible expenses up to $5,000 a year.
Lutheran Brotherhood 625 4th Ave. S Minneapolis MN 55415 (Zip Code: 538-549) Form No. H1-MS-1WI (First three digits) Age: 65 $383.00 Age: 69 $423.00 66 392.00 70-74 454.00 67 404.00 75-79 502.00 68 414.00 80-84 543.00 (Higher in other zip code areas) Additional benefits available at additional cost	Health questions asked (Available only to Lutherans)	6 months	15%	*Hospital* - After initial deductible, policy pays co-insurance. After 150 days, pays 100% of costs *Skilled Nursing Facility* Co-insurance to 100th day. Nothing after that	*Medical* - After you pay $75 deductible, policy pays 30% of usual and customary charges as determined by company

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MEDICARE SUPPLEMENT 3	1986 Annual Premium (subject to change)	Eligibility Standards*	Waiting Period** for Pre-existing Conditions	1st Year Commission to Agent	Brief Description of Benefits*** Medicare Part A	Medicare Part B
Medico Life Insurance/ Mutual Protective Insurance Company 4625 Farnam St. Omaha NE 68132 Form No. ML4085 YL/ MP-485YL Additional benefits available at additional costs	Age:64½-69 $651.10 70-74 775.80 75-79 814.00 80+ 975.75	Health questions asked for 40% and 60% plans	6 months	55%	*Hospital* - Policy pays full deductible and co-insurance. After 150 days, policy pays 100% of Medicare covered charges *Skilled Nursing Facility* Co-insurance to 100th day. Nothing after that	*Medical* - Policy pays $75 deductible and 20% of Medicare-approved charges up to $20,000 in a calendar year
Medico Life Insurance/ Mutual Protective Insurance Company 4625 Farnam St. Omaha NE 68132 Form No. ML4085/ MP 4085 Additional benefits available at additional costs	Age:64½-69 $152.80 70-79 219.50 80+ 290.55	No health questions asked unless rider applied for	6 months	55%	*Hospital* - After initial deductible, policy pays co-insurance. After 150 days, policy pays 100% of Medicare-eligible expenses *Skilled Nursing Facility* Nothing	*Medical* - After you pay $200 deductible, policy pays 20% of Medicare-approved charges up to $20,000 a year
Mutual of Omaha Insurance Company 3301 Dodge Street Omaha NE 68131 Form No. MD12 $462.60		General questions on confinement in hospital and other insurance coverage	6 months	None	*Hospital* - After initial deductible, pays co-insurance to 150th day. After 150 days, 90% of hospital for 365 days maximum lifetime *Skilled Nursing Facility* Co-insurance to 100th day. After 100th day, $20.00 a day for 100 days per benefit period	*Medical* - Policy pays $75 deductible and after an initial deductible of $200 of allowable charges, pays 20% of Medicare-approved charges *Other Benefits* - Policy pays coverage for spouse

	1986 Annual Premium (subject to change)	Eligibility Standards*	Waiting Period** for Pre-existing Conditions	1st Year Commission to Agent	Brief Description of Benefits*** Medicare Part A	Medicare Part B
MEDICARE SUPPLEMENT 3						
Mutual of Omaha Mutual of Omaha Plaza Omaha NE 68175 Form No. M38	Age: 65-69 $393.36 70-74 483.12 75-79 528.96 80+ 579.60	Health questions asked	6 months on ridered conditions	20%	*Hospital* - Policy pays full deductible and co-insurance. After 150 days, pays 90% up to 365 days in lifetime *Skilled Nursing Facility Approved by Medicare* Co-insurance to 100th day. Next 100 days, $20 a day *Skilled Nursing Facility Not Approved by Medicare* Policy pays 30 days at the daily rate established for such nursing homes by the Wisconsin Department of Health and Social Services	*Medical* - After you pay $75 deductible, policy pays 20% of Medicare-approved charges
National Casualty Company P. O. Box 463 Southfield MI 48037 Form No. 8427 MUL Age: 65-69 70-74 75-79 80+ Additional benefits at extra costs	Male Female $567 $484 667 555 764 631 852 701	Health questions asked	6 months	59%	*Hospital* - Policy pays full deductible and co-insurance. After 150 days, pays 90% of costs to a lifetime maximum of 365 days *Skilled Nursing Facility* Co-insurance up to 150 days. After 150th day, $100 a day up to 365 days in a lifetime	*Medical* - After you pay $75 deductible, policy pays 20% of Medicare-approved charge
National States Insurance Co. 11433 Olde Cabin Rd St. Louis MO 63141 Form No. 8864-3 Additional benefits available at additional cost	Age: to 70 $388.00 71-75 449.00 76+ 514.00	Health questions asked	3 months	60%	*Hospital* - Policy pays full deductible and co-insurance. After 150 days, pays next 365 days at 90%. *Skilled Nursing Facility* Co-insurance to 50th day. Nothing after that	*Medical* - After $75 deductible, policy pays 20% of usual and customary charges up to $5,000 in a calendar year

MEDICARE SUPPLEMENT 3	1986 Annual Premium (subject to change)	Eligibility Standards*	Waiting Period** for Pre-existing Conditions	1st Year Commission to Agent	Brief Description of Benefits*** Medicare Part A	Medicare Part B
National Travelers Life Co. 820 Keosauqua Way Des Moines IA 50308 Form No. MP6160 WI 4-83	Age: 65 $564.00; 66 598.00; 67 635.00; 68 672.00; 69 717.00; 70+ 775.00	Health questions asked	6 months	35%	*Hospital* - Policy pays full deductible and co-insurance. After 150th day, policy pays 100% of eligible expenses to 365th day *Skilled Nursing Facility* Policy pays co-insurance to 100th day, pays $75 a day for 265 days in a benefit-period	*Medical* - After $75 deductible, policy pays 40% of reasonable charges up to $5,000 maximum per year
New York Life Ins. Co. 51 Madison Avenue New York NY 10010 Form No. 8145-8 Individual / Family Basis Age: Male $528.00 / Female $488.40 / Male $508.20 / Female $468.60 70-74: 613.80 / 567.60 / 594.00 / 554.40 75-79: 686.40 / 627.00 / 660.00 / 613.80 80-84: 732.60 / 693.00 / 719.40 / 679.80		No health questions asked	6 months	30%	*Hospital* - Policy pays full deductible and co-insurance. After 150 days, policy pays reasonable charges up to 365 days *Skilled Nursing Facility* Co-insurance to 100th day	*Medical* - After $75 deductible, policy pays 20% of Medicare-approved charges or reasonable charges as determined by company, whichever is greater
Union Labor Life Insurance Co 111 Massachusetts Ave., NW Washington DC 20001 Form No. Ind. A.H. 5093-83 30% and 40% Part B options available at additional cost	Age: 20% 65-74 $574.00 75% 815.00	General questions on current confinement in hospital or nursing home	6 months	40%	*Hospital* - Policy pays full deductible and co-insurance. After 150 days, policy pays 90% of expenses up to 365 days *Skilled Nursing Facility* Co-insurance to 100th day.	*Medical* - Policy pays $75 deductible plus 20% of Medicare-eligible charges up to maximum benefit of $5,000

1986 Annual Premium (subject to change)	Eligibility Standards*	Waiting Period** for Pre-existing Conditions	1st Year Commission to Agent	Brief Description of Benefits*** Medicare Part A	Medicare Part B
MEDICARE SUPPLEMENT 3					
United American Ins. Co. 2909 W. Buchner Blvd. Dallas TX 75221 $770 (for everyone) Form MAXC (48)	Health questions asked	60 days	60%	*Hospital* - Policy pays initial deductible and co-insurance. After 150 days, pays 100% of expense. *Skilled Nursing Facility* Co-insurance to 100th day. After 100th day, pays $38 a day for 265 days	*Medical* - After $75 deductible, policy pays 20% of allowable charge. After first $200 of Medicare-eligible expense in excess of Medicare approved amount, 80% of each subsequent item of excess but not to exceed 50% of amount approved by Medicare for item
United American Ins. Co. 2909 W. Buckner Blvd. Dallas TX 75221 $572 for everyone Form DMXC (48) 65 and over $737 for everyone under 65 and on disability	Health questions asked	6 months	60%	*Hospital* - Policy pays initial deductible and co-insurance. After 150 days, pays 90% of expense up to 365 days *Skilled Nursing Facility* Co-insurance to 100th day. After 100th day, nothing	*Medical* - After first $200, out-of-pocket, of Medicare-approved charges, policy pays 20% Medicare-approved charges
United American Ins. Co. P.O. Box 810 Dallas TX 75221 $671 for everyone Form MVXC (48)	Health questions asked	60 days	60%	*Hospital* - Policy pays deductible and co-insurance to 100th day. After 150 days pays 90% up to 365 days *Skilled Nursing Facility* Co-insurance to 100th day	*Medical* - After you pay $75 deductible, policy pays 20% of Medicare-approved charges
United American Insurance Company P. O. Box 810 Dallas TX 75221 Form No. MAXC + (48) $803 for everyone	Health questions asked	60 days	60%	*Hospital* - Policy pays full deductible and co-insurance *Skilled Nursing Facility* Co-insurance to the 100th day. Pays $50 a day for 265 days	*Medical* - After $75 deductible, 50% of covered expense not paid by Medicare. Covered expense is up to 140% of Medicare-approved charge. After $200 of benefits paid in calendar year, all additional covered expense not covered by Medicare is paid *Other Benefits* - In-hospital private nursing care. Premium refund for accidental death

MEDICARE REPLACEMENT****	1986 Annual Premium (submit to change)	Eligibility Standards*	Waiting Period** for Pre-existing Conditions	1st Year Commission to Agent	Brief Description of Benefits*** Medicare Part A	Medicare Part B
Family Health Plan Cooperative 12500 W. Bluemound Road Elm Grove WI 53122-0925 Form No. M-10-85-A	$275.88 for everyone	None	None	None	*Hospital* - In addition to regular Medicare benefits, policy pays full deductible and co-insurance. After 100 days, pays 100% *Skilled Nursing Facility* Co-insurance to 100th day. After 100th day, 100% of charges	*Medical* - In addition to regular Medicare, policy pays 100% of medical expenses approved by Family Health Plan physician *Other Benefits* - Vision and dental benefits available at additional cost
Available in Milwaukee, Ozaukee, Racine, Walworth, Washington and Waukesha Counties only						

* Whenever an application includes health questions, the company may use this information to refuse to issue a policy, to limit or exclude the coverage for a specific named condition for six months or void the policy because of misinformation on the application.

** Pre-existing condition waiting periods may be applied only to conditions for which you were treated in the 6 months before you applied for the policy and which have not been disclosed on the application or excluded by specific description.

*** This is a brief description of benefits. Check the Outline of Coverage and the policy itself for details. YOUR MEDICARE HANDBOOK, available from your Social Security office, explains Medicare benefits. Skilled Nursing Facility benefits are provided only if stay is covered by Medicare.

**** A Medicare Replacement policy is a policy offered by a health maintenance organization which has entered into a direct risk contract with the federal government to provide Medicare benefits to enrollees. In Wisconsin these policies are required to offer additional benefits. Full benefits generally are paid only if services are received from participating providers in the geographical area served by the plan.

Medicare Part A covers hospitalization, including room and board, nursing charges and miscellaneous charges. Medicare pays first 60 days in full after $492. From the 61st through 150th day, costs are shared. After 150th day, Medicare pays nothing. Medicare also covers some posthospital stays in a Skilled Nursing Facility. If the stay is covered, Medicare pays for the first 20 days. From the 21st through 100th day, costs are shared. After 100th day, Medicare pays nothing.

Medicare Part B covers many medical costs. After $75 annual deductible, Medicare pays 80% of Medicare-approved charges for covered expenses. Most companies pay Part B benefits based on Medicare's approved charges. Some companies make their own determinations of usual and customary charges. Medicare-approved charges and usual and customary charges as determined by the company are often less than you are actually charged by a doctor or other health professional.

MEDICARE SUPPLEMENT EXPERIENCE
(POLICIES MARKETED IN 1983)

MEDICARE SUPPLEMENT 2

Name of Company	Policy Form #	No. in Force (12/31/83)	No. Issued 1983	No. excluded or rejected	Earned premium 1983	Incurred Claims 1983	Loss Ratio 1983
Aid Assoc. for Luth.	4717WI[1]	1,018	389	20 ex. 95 rej.	$ 418,551	$ 137,737	32.9%
Benefit Trust Life Co.	#MSW-182	615	620	0	$ 147,199	$ 45,553	31.0%
Blue Cross & Blue Shield United of Wisconsin	HX-1425	6,746	4,800	0	$1,871,941	$ 1,194,473	63.8%
Central States	#286 WISC	851	947		$ 131,664	$ 19,638	15.0%
Continent. Cas	#67720	3,853	2,318	0	$1,658,513	$ 1,304,855	78.7%
Federal Home Life Ins. Co.	#4500 #4535(S)	2,110 136	1,958 136	N/A	$ 958,031 $ 12,272	$ 518,371 $ 3,948	54.1% 32.2%
Nat. States	SMW-2	40	43	41	$ 23,121	$ 0	—
Physicians Mut. Ins. Co.	P192K and 182	12,095	6,434	65	$4,325,377	$ 2,891,628	67%
Rural Sec. Life	#HP-191	2,546	248	220 rej.	$1,113,288	$ 890,501	80%
Time Insurance Company	#682	277	0	0	$ 94,811	$ 20,425	21%
WPS	#13789-R51	4,533	3,662	946	$ 932,081	$ 652,660	70%
Total		34,684	21,555	1,387	$11,686,849	$ 7,679,789	Avg. 49.54%

1. Also includes #4732 and #4732 2-81.
N/A = Not Available

1000G-1

Prepared by: Mary Grossman
06/28/84

MEDICARE SUPPLEMENT EXPERIENCE
(POLICIES MARKETED IN 1983)

MEDICARE SUPPLEMENT 3

Name of Company	Policy Form #	No. in Force (12/31/83)	No. Issued 1983	No. excluded or rejected	Earned premium 1983	Incurred Claims 1093	Loss Ratio 1983
Am. Rep.	A-2400 WI	190	65	13	$ 72,722	$ 40,572	56%
Bankers Life	GW1519	4	4	N/A	N/A	N/A	N/A
Bankers Life & Casualty	75D(1982)	2,591	1,926	0	$ 1,323,464	$ 840,276	63.5%
Bankers Life & Casualty	#75R	434	485	0	$ 20,864	$ 8,342	40.0%
Benefit Trust Life Co.	MSP-182WI	211	213	0	$ 36,727	$ 10,961	30.0%
Globe Life & Accident	#MCP-2-MWI	101	101	0	$ 34,297	$ 29,906	87.0%
Guarantee Trust Life	#80335	1,679	N/A	0	$ 241,479	$ 41,760	17.3%
Lutheran Brotherhood	H1-MS-1W1	137	151	0	$ 19,378	$ 7,668	39.6%
Medico Life	#ML408	35	37	1	$ 1,038	$ 160	15%
Medico Life	#ML384Y	67	71	2	$ 20,312	$ 7,549	37%
MidAmerica Mutual Life	U-1085.3[2]	292	94	30	$ 114,281	$ 41,275	36.2%
Mutual of Omaha	M-37 Series	1,381	1,265	0	$ 387,525	$ 156,246	40.32%
Mutual of Omaha	M39-Series	3,948	3,749	0	$ 1,025,408	$ 551,284	53.76%
Mut.Protective	#MP408	381	442	4	$ 19,955	$ 6,826	34%
Mut.Protective	#MP384Y	238	287	4	$ 109,845	$ 34,700	31%
Nat. States	SMW-3	1,623	1,588	1,032	$ 797,036	$ 84,894	10.7%
Nat. Travelers Life	#6160 WI	13	14	1	$ 3,081	0	0
New York Life Ins. Co.	#8145-8	7	7	0	$ 3,219	$ 1,608	50%
Total		13,332	10,570	1,078	$ 4,230,631	$1,864,027	Avg. 40.0%
TOTAL ALL POLICIES		48,016	32,125	2,474	$15,917,480	$3,728,054	Avg. 44%

2. Includes all Medicare Supplement policies.
N/A = Not Available
1000G-2

Prepared by: Mary Grossman
06/28/84

62-241 O - 86 - 9

1983 MEDICARE SUPPLEMENT EXPERIENCE*
ALL MEDICARE SUPPLEMENT POLICIES IN FORCE DECEMBER 31, 1983

Name of Company	Total in Force 12/31/83	1983 Earned Premium	1983 Incurred Claims	1983 Loss Ratio
Aid Assn. Lutherans	1,018	$ 418,551	$ 137,737	32.9%
American Republic	190	76,186	42,246	55.0
Bankers Life	4,487	-	-	-
Bankers Life & Cas.	11,967	8,077,554	4,553,803	56.4
Benefit Trust Life	833	183,926	56,514	30.73
Blue Cross & Blue Shield	105,315	32,328,148	27,171,388	84.0
Cent. Sts. Health & Life	890	150,179	27,277	18.0
Continental Casualty	4,242	1,724,562	1,365,826	79.0
Federal Home Life	2,558	1,181,181	660,350	55.9
Globe Life	225	75,589	56,719	75.0
Interstate Assur.	36	10,173	6,618	65.0
Lumbermens Mutual	60	113,255	104,478	92.0
Lutheran Brotherhood	233	24,270	10,380	43.0
Mass. Indemnity Life	29	5,126	1,025	20.0
Medico Life	206	46,564	35,062	75.0
MidAmerica Mut. Life	292	114,281	41,275	36.2
Mutual of Omaha	11,185	4,986,262	2,883,698	57.83
Mutual Protective	671	140,990	46,680	33.0
National Home Life	90	40,401	29,897	74.0
National States	3,043	1,248,539	442,292	35.4
National Travelers	13	3,081	-	-
New York Life	14	7,049	2,522	35.8
Pennsylvania	79	20,024	4,168	24.73
Physicians Mutual	12,095	4,325,377	2,891,628	67.0
Rural Security	2,546	1,113,288	890,501	80.0
Time	822	365,804	146,992	40.0
Union Labor	38	3,230	5,703	177.0
WPS	34,664	23,957,065	16,991,912	70.9
Total	197,841	$80,740,655	$58,606,691	58.2%

* Includes all companies reporting Medicare Supplement business in 1983.

1108G

6/27/84

Prepared by:
Mary Grossman

Name of Company	Policy Form Number	Number in Force 12/31/84	Number Issued 1984	Number Excluded or Rejected	Earned Premium 1984	Incurred Claims 1984	Loss Ratio 1984
Mutual Protective Ins Co	Individual						
	385	37	0	0	7,849	5,083	64.76
	384Y	255	177	4	183,996	66,099	35.92
	408	608	519	1	109,021	29,608	27.16
National Home Life Assurance Co	Individual						
	4200 WI	74	0	0	37,165**	25,857**	70.0**
	** Estimated						
National States Ins Co	SMW	946	0	0	333,149	163,545	49.1
	SMW-3	1,429	619	588	743,179	412,296	55.5
	SMW-2	437	483	459	281,895	13,873	4.9
National Travelers Life Co	Other						
	HP6160 WI	28	18	0	10,667	7,196	67.46
New York Life Ins Co	8145-8	237	230	0	84,869	66,676	78.6
	7745	7	0	0	3,073	3,284	106.9
Pekin Life Ins Co	H10	5	5	0	2,060	797	38.22
	H15	13	13	0	5,556	3,164	56.95
Physicians Mutual Ins Co	192K	4,262	3,461	36	1,556,853	899,861	57.8
	182	8,764	0	0	5,344,613	3,302,971	61.8
Rural Security Life Ins Co	HP-191	2,605	198	100	1,275,000	891,500	69.9
Time Ins Co	603	452	0	0	206,981	108,406	41.5
	682	374	200	14	232,280	109,383	47.1
Union Labor Life Ins Co	Individual						
	Ind. A.H. 5065	6	3	0	510	798	156.0
	Ind. A.H. 5090-83	318	318		95,231	75,226	79.00

Name of Company	Policy Form Number	Number in Force 12/31/84	Number Issued 1984	Number Excluded or Rejected	Earned Premium 1984	Incurred Claims 1984	Loss Ratio 1984
	Other						
	78322-5	5	0	0	1,984	355	17.8
	80335	2,831	0	0	707,384	160,168	22.6
	80369R-1	2,683	0	0	357,824	234,545	65.5
	81337R-7	801	0	0	214,079	210,967	98.5
	81337R-8	1,922	0	0	255,906	284,762	111.2
	23916	82	0	0	42,795	16,315	38.1
Lutheran Brotherhood	Individual						
	HI-MS-I	210	198	0	80,885	25,223	31.2
	HRI-MDC	159	78	0	22,137	12,248	55.3
Medico Life Ins Co	Other						
	384Y	228	243	6	90,259	23,677	26.23
	408	112	120	1	15,073	4,170	27.66
MidAmerica Mutual	U-1085	420	162	15	166,409	59,935	36.0
Mutual of Omaha Ins Co	Other						
	50VB	1,732	0	0	856,462	410,526	47.93
	51VB	888	0	0	422,140	241,999	57.33
	20AGHO	42	0	0	23,610	8,652	36.65
	2CMO	221	0	0	119,592	52,281	43.72
	3CMO	88	0	0	50,071	26,103	52.13
	15CMO	243	0	0	246,094	102,931	41.83
	16CMO	506	0	0	500,596	182,331	36.42
	44CMO	186	0	0	125,780	55,907	44.45
	48CMO	3	0	0	1,917	0	0
	50CMO	303	0	0	293,720	142,843	48.63
	51CMO	14	0	0	13,089	5,872	44.86
	M37	1,783	922	0	915,375	352,285	38.49
	M39	5,071	2,326	0	3,555,401	1,649,964	46.41

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08/20/85

Name of Company	Policy Form Number	Number in Force 12/31/84	Number Issued 1984	Number Excluded or Rejected	Earned Premium 1984	Incurred Claims 1984	Loss Ratio 1984
Central States Health & Life Co of Omaha	Individual						
	219	14	0	0	6,986	3,211	46.0
	279	8	0	0	6,356	622	10.4
	282	2	0	0	972	411	42.3
	Other						
	286	1,656	1,581	0	788,131	333,633	42.3
	288	5	6	0	2,922	4,624	158.2
	289	8	4	0	1,175	(11,530)	0.0
Continental Casualty Co	Other						
	65000	36			2,333	5,306	227.4
	65003	278			49,982	(17,978)	0
	66353	4			1,858	2,309	124.3
	67720	4,242	1,573		2,328,049	335,530	14.4
DeanCare	Other						
	1059-0484	1,007	1,007	0	150,051	149,588	99.0
Globe Life & Accident Co	Individual						
	OA640	84	0	0	31,647	14,641	46.0
	Medsup-2	7	0	0	4,000	7,538	188.0
	MCP-2	60	0	0	54,841	33,989	62.0
	MCP-3	12	12	0	2,641	409	15.0
	Great Commonwealth	3	0	0	599	528	88.0
Greater Marshfield Community Health Plan	Individual						
	PGP-631	9,829	N/A	0	5,952,023	4,954,173	83.2
Federal Home Life Ins Co	Other						
	4492	272	0	0	192,716	96,566	50.1
	4500	1,276	0	0	992,655	443,187	44.6
	4535	617	475	0	332,337	144,698	43.5
Guarantee Trust Life Ins Co	Individual						
	71306-R	31	0	0	571	19	3.3
	80331	59	0	0	32,190	12,772	39.6
	71306	451	0	0	181,815	139,167	76.5

MEDICARE SUPPLEMENT BUSINESS - 1984

Name of Company	Policy Form Number	Number in Force 12/31/84	Number Issued 1984	Number Excluded or Rejected	Earned Premium 1984	Incurred Claims 1984	Loss Ratio 1984
Aid Assoc for Lutherans	Individual						
	47322-81	1,454	523	24 excluded 175 rejected	$ 697,991	$ 254,952	36.5%
Am. Motorists Ins Co	Other						
	IM 5847	0	0	0	450	(316)	(70.2)
Am. Republic Ins Co	Individual						
	A-2400	211	59	12	95,866	44,850	47.0
	A-2535 (Rider)	78	40	9	8,221	7,044	86.0
Bankers Life & Casualty	Individual						
	75D	4,274	0	0	4,424,535	1,689,537	38.2
	75D (1982)	1,346	107	0	1,159,154	514,564	44.4
	75R	4,529	4,870	0	4,039,329	2,127,617	52.7
	97F	1,226	1,251	0	387,750	67,167	17.3
Benefit Trust Life Ins Co	Individual						
	MSP-182WI	287	129	0	162,159	61,475	37.91
	MSW-182	908	499	0	511,926	258,182	50.43
Blue Cross & Blue Shield United of Wisconsin	Group						
	Medicare Extended	6,688	488*	0	1,960,150	1,743,603	89.0
	Medex Preferred	695	131*	0	255,872	228,200	89.2
	Medex - Plus	819	572*	0	267,417	174,425	65.2
	Individual						
	Medex - Preferred	33,667	0	0	15,464,031	11,889,343	76.9
	Other Individual						
	Medex - Plus	19,572	13,974*	56 rejected	4,871,399	3,011,937	61.8
	Medicare Extended	41,901	0	0	13,371,826	12,667,739	94.7

* These figures represent new sales and/or transfers from non-Medicare contracts.

49c1
08/20/85

Name of Company	Policy Form Number	Number in Force 12/31/84	Number Issued 1984	Number Excluded or Rejected	Earned Premium 1984	Incurred Claims 1984	Loss Ratio 1984
United American Ins Co	MCXC	1,082	0	0	538,623	366,783	68.1
	MAXC	4,146	4,963	0	1,375,010	246,063	17.9
	DMXC	863	921	0	272,839	29,961	11.0
Wisconsin Physicians Service Ins Co	Individual						
	WPS MedPlus #22500-725	17,809	0	0	20,254,201	15,370,612	75.9
	Med. PlusConv 10524-051-8107	470	200	0	0	0	0.0
	Med. Comp. 1193-051-8106	8,710	0	0	3,288,949	1,925,581	58.5
	Other						
	Med. Comp. II-13789-B51-8207	6,553	2,342	576	2,128,002	1,069,567	50.3
TOTAL		218,639	46,020	2,076	106,245,078	70,851,981	66.6

49c5
08/20/85

Prepared by: Carol Waugh
Mary Grossman
Office of the Commissioner of Insurance
123 West Washington Avenue
Madison WI 53702

APPENDIX H

VOLUNTARY CERTIFICATION OF MEDICARE SUPPLEMENTAL HEALTH INSURANCE POLICIES

SEC. 507. (a) Title XVIII of the Social Security Act is amended by adding at the end thereof the following new section:

"VOLUNTARY CERTIFICATION OF MEDICARE SUPPLEMENTAL HEALTH INSURANCE POLICIES

42 USC 1395ss.

"SEC. 1882. (a) The Secretary shall establish a procedure whereby medicare supplemental policies (as defined in subsection (g)(1)) may be certified by the Secretary as meeting minimum standards and requirements set forth in subsection (c). Such procedure shall provide an opportunity for any insurer to submit any such policy, and such additional data as the Secretary finds necessary, to the Secretary for his examination and for his certification thereof as meeting the standards and requirements set forth in subsection (c). Such certification shall remain in effect if the insurer files a notarized statement with the Secretary no later than June 30 of each year stating that the policy continues to meet such standards and requirements and if the insurer submits such additional data as the Secretary finds necessary to independently verify the accuracy of such notarized statement.

Emblem.

Where the Secretary determines such a policy meets (or continues to meet) such standards and requirements, he shall authorize the insurer to have printed on such policy (but only in accordance with such requirements and conditions as the Secretary may prescribe) an emblem which the Secretary shall cause to be designed for use as an indication that a policy has received the Secretary's certification. The Secretary shall provide each State commissioner or superintendent of insurance with a list of all the policies which have received his certification.

List of certified policies.

State regulatory program, standards and requirements.

"(b)(1) Any medicare supplemental policy issued in any State which the Supplemental Health Insurance Panel (established under paragraph (2)) determines has established under State law a regulatory program that—

"(A) provides for the application of standards with respect to such policies equal to or more stringent than the NAIC Model Standards (as defined in subsection (g)(2)(A));

"(B) includes a requirement equal to or more stringent than the requirement described in subsection (c)(2); and

"(C) provides for application of the standards and requirements described in subparagraphs (A) and (B) to all medicare supplemental policies (as defined in subsection (g)(1)) issued in such State,

shall be deemed (for so long as the Panel finds that such State regulatory program continues to meet the standards and requirements of this paragraph) to meet the standards and requirements set forth in subsection (c).

Supplemental Health Insurance Panel, establishment.

"(2)(A) There is hereby established a panel (hereinafter in this section referred to as the 'Panel') to be known as the Supplemental Health Insurance Panel. The Panel shall consist of the Secretary, who shall serve as the Chairman, and four State commissioners or superintendents of insurance, who shall be appointed by the President and serve at his pleasure. Such members shall first be appointed not later than December 31, 1980.

Quorum.

"(B) A majority of the members of the Panel shall constitute a quorum, but a lesser number may conduct hearings.

"(C) The Secretary shall provide such technical, secretarial, clerical, and other assistance as the Panel may require.

"(D) There are authorized to be appropriated such sums as may be necessary to carry out this paragraph. Appropriation authorization.

"(E) Members of the Panel shall be allowed, while away from their homes or regular places of business in the performance of services for the Panel, travel expenses (including per diem in lieu of subsistence) in the same manner as persons employed intermittently in the Government service are allowed expenses under section 5703 of title 5, United States Code. Travel expenses.

"(c) The Secretary shall certify under this section any medicare supplemental policy, or continue certification of such a policy, only if he finds that such policy— Medicare supplemental policy, certification criteria.

"(1) meets or exceeds (either in a single policy or, in the case of nonprofit hospital and medical service associations, in one or more policies issued in conjunction with one another) the NAIC Model Standards; and

"(2) can be expected (as estimated for the entire period for which rates are computed to provide coverage, on the basis of incurred claims experience and earned premiums for such period and in accordance with accepted actuarial principles and practices) to return to policyholders in the form of aggregate benefits provided under the policy, at least 75 percent of the aggregate amount of premiums collected in the case of group policies and at least 60 percent of the aggregate amount of premiums collected in the case of individual policies.

For purposes of paragraph (2), policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be individual policies. Individual policies.

"(d)(1) Whoever knowingly or willfully makes or causes to be made or induces or seeks to induce the making of any false statement or representation of a material fact with respect to the compliance of any policy with the standards and requirements set forth in subsection (c) or in regulations promulgated pursuant to such subsection, or with respect to the use of the emblem designed by the Secretary under subsection (a), shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than 5 years, or both. False statement or representation, penalties and fines.

"(2) Whoever falsely assumes or pretends to be acting, or misrepresents in any way that he is acting, under the authority of or in association with, the program of health insurance established by this title, or any Federal agency, for the purpose of selling or attempting to sell insurance, or in such pretended character demands, or obtains money, paper, documents, or anything of value, shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than 5 years, or both.

"(3)(A) Whoever knowingly sells a health insurance policy to an individual entitled to benefits under part A or enrolled under part B of this title, with knowledge that such policy substantially duplicates health benefits to which such individual is otherwise entitled, other than benefits to which he is entitled under a requirement of State or Federal law (other than this title), shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than 5 years, or both. 42 USC 1395c, 1395j.

consumers and the aged, conduct a comprehensive study and evaluation of the comparative effectiveness of various State approaches to the regulation of medicare supplemental policies in (i) limiting marketing and agent abuse, (ii) assuring the dissemination of such information to individuals entitled to benefits under this title (and to other consumers) as is necessary to permit informed choice, (iii) promoting policies which provide reasonable economic benefits for such individuals, (iv) reducing the purchase of unnecessary duplicative coverage, (v) improving price competition, and (vi) establishing effective approved State regulatory programs described in subsection (b).

"(B) Such study shall also address the need for standards or certification of health insurance policies, other than medicare supplemental policies, sold to individuals eligible for benefits under this title.

"(C) The Secretary shall, no later than January 1, 1982, submit a report to the Congress on the results of such study and evaluation, accompanied by such recommendations as the Secretary finds warranted by such results with respect to the need for legislative or administrative changes to accomplish the objectives set forth in subparagraphs (A) and (B), including the need for a mandatory Federal regulatory program to assure the marketing of appropriate types of medicare supplemental policies, and such other means as he finds may be appropriate to enhance effective State regulation of such policies. Report to Congress.

"(2) The Secretary shall submit to the Congress no later than July 1, 1982, and periodically as may be appropriate thereafter (but not less often than once every 2 years), a report evaluating the effectiveness of the certification procedure and the criminal penalties established under this section, and shall include in such reports an analysis of— Report to Congress.

"(A) the impact of such procedure and penalties on the types, market ...are, value, and cost to individuals entitled to benefits under this title of medicare supplemental policies which have been certified by the Secretary;

"(B) the need for any change in the certification procedure to improve its administration or effectiveness; and

"(C) whether the certification program and criminal penalties should be continued.

"(g)(1) For purposes of this section, a medicare supplemental policy is a health insurance policy or other health benefit plan offered by a private entity to individuals who are entitled to have payment made under this title, which provides reimbursement for expenses incurred for services and items for which payment may be made under this title but which are not reimbursable by reason of the applicability of deductibles, coinsurance amounts, or other limitations imposed pursuant to this title; but does not include any such policy or plan of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations (or combination thereof), for employees or former employees (or combination thereof) or for members or former members (or combination thereof) of the labor organizations. For purposes of this section, the term 'policy' includes a certificate issued under such policy. Medicare supplemental policy, definition. "Policy."

"(2) For purposes of this section:

"(A) The term 'NAIC Model Standards' means the 'NAIC Model Regulation to Implement the Individual Accident and Sickness Insurance Minimum Standards Act', adopted by the "NAIC Model Standards."

National Association of Insurance Commissioners on June 6, 1979, as it applies to medicare supplement policies.

Definition.

"(B) The term 'State with an approved regulatory program' means a State for which the Panel has made a determination under subsection (b)(1).

"(C) The State in which a policy is issued means—

"(i) in the case of an individual policy, the State in which the policyholder resides; and

"(ii) in the case of a group policy, the State in which the holder of the master policy resides.

Regulations.

"(h) The Secretary shall prescribe such regulations as may be necessary for the effective, efficient, and equitable administration of the certification procedure established under this section. The Secretary shall first issue final regulations to implement the certification procedure established under subsection (a) not later than March 1, 1981.

Emblem usage, effective date.

"(i)(1) No medicare supplemental policy shall be certified and no such policy may be issued bearing the emblem authorized by the Secretary under subsection (a) until July 1, 1982. On and after such date policies certified by the Secretary may bear such emblem, including policies which were issued prior to such date and were subsequently certified, and insurers may notify holders of such certified policies issued prior to such date using such emblem in the notification.

"(2)(A) The Secretary shall not implement the certification program established under subsection (a) with respect to policies issued in a State unless the Panel makes a finding that such State cannot be expected to have established, by July 1, 1982, an approved State regulatory program meeting the standards and requirements of subsection (b)(1). If the Panel makes such a finding, the Secretary shall implement such program under subsection (a) with respect to medicare supplemental policies issued in such State, until such time as the Panel determines that such State has a program that meets the standards and requirements of subsection (b)(1).

Panel findings, transmittal to congressional committees, effective date.

"(B) Any finding by the Panel under subparagraph (A) shall be transmitted in writing, not later than January 1, 1982, to the Committee on Finance of the Senate and to the Committee on Interstate and Foreign Commerce and the Committee on Ways and Means of the House of Representatives and shall not become effective until 60 days after the date of its transmittal to the Committees of the Congress under this subparagraph. In counting such days, days on which either House is not in session because of an adjournment sine die or an adjournment of more than three days to a day certain are excluded in the computation.

"(j) Nothing in this section shall be construed so as to affect the right of any State to regulate medicare supplemental policies which, under the provisions of this section, are considered to be issued in another State.".

(b) The amendment made by this section shall become effective on the date of the enactment of this Act, except that the provisions of paragraph (4) of section 1882(d) of the Social Security Act (as added by this section) shall become effective on July 1, 1982.

Effective date. 42 USC 1395ss note.

Ante, p. 476.

Approved June 9, 1980.

LEGISLATIVE HISTORY:

HOUSE REPORTS: No. 96-100 (Comm. on Ways and Means) and No. 96-944 (Comm. of Conference).
SENATE REPORT No. 96-408 (Comm. on Finance).
CONGRESSIONAL RECORD
Vol. 125 (1979): Sept. 6, considered and passed House.
Dec. 4, considered in Senate.
Vol. 126 (1980): Jan. 30, 31, considered and passed Senate, amended.
May 22, House agreed to conference report.
May 29, Senate agreed to conference report.
WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS
Vol. 16, No. 24 (1980): June 9, Presidential statement.

APPENDIX I

SUPREME COURT : NEW YORK COUNTY VZ 9

SPECIAL TERM : PART I

----------X

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS,

Plaintiff,

- against -

AMERICAN BROADCASTING COMPANIES, INC., et al.,

Defendants.

INDEX NO. 20674/79

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ALFRED M. ASCIONE, J.:

In this libel action, seeking damages of $175 million, brought by plaintiff American Family Life Assurance Company of Columbus [Georgia] ("AFLAC") against the defendants American Broadcasting Companies, Inc. ("ABC"), Roone Arledge, Av Westin, Margaret Osmer, Karen Burns, et al., in connection with a three-part series entitled "Insurance Fraud" and broadcast by ABC on its television network as part of the regularly scheduled evening news program, "World News Tonight", on November 27, 28 and 29, 1978, defendants' motion for summary judgment dismissing the complaint is granted.

First, some background. AFLAC is a wholly-owned subsidiary of the American Family Corporation of Columbus, Georgia, a public company listed on the New York Stock Exchange, and was incorporated in 1955 by its founder and chairman, John B. Amos, an attorney. By the time of the broadcasts in question, in

1978, AFLAC was the number-one seller of cancer insurance in the United States (see Exhibit H to the moving papers, Consumer Reports, June 1978, p. 336, "Cashing In On Fear: The Selling of Cancer Insurance"). Indeed, cancer insurance had become such a hot item that plaintiff was selling 3,000 policies a day and had a total of over 4.7 million cancer policies in force worldwide covering 12 million people.

By its own account, AFLAC now sells the major share of cancer (sometimes called "dread disease") insurance sold in the world. Mr. Amos, in AFLAC advertisements published nationally during 1977, said: "Our company issues and has in force more insurance policies limited to loss from cancer than all other insurance companies in the world combined." (See advertisement with headline "Twenty Years of Stewardship -- Cancer Insurance Comes of Age," Exhibit H to moving affidavit).

However, three states, New York, New Jersey and Connecticut, have adopted strict restrictions on or banned the sale of cancer insurance and plaintiff does not sell such insurance in those states.

According to plaintiff, its cancer insurance, though supplemental in nature, is not designed to meet the so-called "Medigap", which is the ever-widening gap between what Medicare pays and the actual medical costs of our elderly. By far, the majority of AFLAC's policyholders are not the elderly. It does

appear, however, that 11.1% or some 462,000 of plaintiff's policyholders were over the age of sixty-five in 1978, a significant number.

Blue Cross/Blue Shield and a number of major insurance companies do offer comprehensive health insurance intended to narrow the medigap and to provide supplemental protection to the elderly against cancer or any other medical condition beyond what Medicare pays (Medicare paid 38% in 1978), though no insurance completely fills the gap.

Then, we find AFLAC and the other insurers who have been very successful selling cancer insurance in response to the widespread fear of this dread disease and the substantial medical costs involved. Whether or not such insurance is intended to recover medical costs not reimbursed by Medicare, the elderly are particularly vulnerable to the lure of insurance protection against cancer because Medicare will pay only 38% of their medical costs, which they know will be substantial and may drain their remaining resources. For example, AFLAC in its 1977 advertisement "Cancer Insurance Comes of Age" stated:

> "We feel, however, that above all else our cancer policy provides to the insured Peace of Mind. Peace of mind that enough money will be available to fill the gaps --- to insure that he will never be a burden upon loved ones -- that life savings or plans for college educations and a fair start in life for the coming generation -- will not be destroyed by a long and expensive battle with cancer ..."

The record in this case shows that, in 1978, two/thirds of the American elderly, or 15 million people, had at least one medi-gap policy; many had two or more and some as many as thirty policies. It is estimated that almost $4 billion was spent by the elderly in 1978 on such policies. Of that amount, Blue Cross accounted for $2 billion and group insurers about $500 million. Some $1.5 billion was spent on policies sold to individuals by companies such as AFLAC. The ABC series was concerned with the latter group of insurers.

Serious questions had been raised about the marketing, sales and claims practices of some of the insurers and agents selling cancer insurance. Although these companies did not create the climate of fear which exists about cancer, little reluctance was shown in making the most of it in their marketing or sales pitch to the elderly, who, as noted, are especially susceptible to sales techniques which prey on such fear and the inadequacy of Medicare benefits should they fall victim to cancer.

Such fear has led to abuses by some unscrupulous insurers and their agents who "overload" senior citizens with a number of policies which are duplicative and may cancel each other out due to coordination of benefits clauses. Also, a number of companies have very low loss/benefit ratios, that is, the amount paid on claims in proportion to the premiums received. Insurance experts tell us that the higher the loss/benefit ratio the better it is for the policyholders. Blue Cross, for example, pays 80 cents or more for each dollar of premium. Some companies have

loss/benefit ratios of under 50 cents (in this case, it is asserted that plaintiff's loss/benefit ratio for 1977 was about 43 cents). Such low ratios are an indication that most of the premium dollar goes to pay agents' commissions, high overhead and administrative costs, and profits, rather than claims.

Thus, it is clear that there was and is a public controversy concerning the efficacy or economic value of dread disease or single-purpose supplemental health insurance for the elderly, when compared to supplemental comprehensive health insurance such as that offered by Blue Cross/Blue Shield or the other major commercial insurance companies. Obviously, should a policyholder suffer from a disease or medical condition other than the specific ailment insured, no coverage is afforded. Such policies commonly contain exclusions or waiting periods for pre-existing conditions, and a level of benefits for hospitalization, physicians' fees and other medical expenses, when there is coverage, that often fails to meet the real need of the elderly for genuine supplementary or medigap protection, and which the elderly are falsely led to believe such insurance afforded.

Due to a significant number of complaints concerning such abuses to the Select Committee on Aging of the U.S. House of Representatives in the 95th Congress, Second Session, the Committee Staff was directed to conduct an investigation on the subject, "Abuses in the Sale of Health Insurance to the Elderly in Supplementation of Medicare."

In late August or early September, 1978, ABC was invited by the Select Committee to cover the investigation and subsequent hearing as a national news event, and to set up hidden cameras to record undercover sessions with agents and to interview witnesses who would be testifying before the Committee.

It appears that the broadcast of ABC's three-part series on the "World Nightly News" was timed to coincide with the Select Committee's hearing conducted on November 28, 1978 and the issuance of the Staff Study report of the same date, which sets forth the results of the Staff Study investigation. Portions of the report were made available to ABC prior to November 28, 1978.

The 444-page report, entitled: "Abuses in the Sale of Health Insurance to the Elderly in Supplementation of Medicare: A National Scandal," contains the results of a 6 month investigation. According to the Staff Director, Robert S. Weiner, and Special Counsel, Val J. Halamandaris:

> "This study [was] the first detailed national investigation of the problem. Every State department of insurance and the great majority of companies selling Medicare supplemental insurance policies to the elderly have been surveyed. For the first time, large numbers of Senior Citizens have been asked about their problems with such policies. In addition, the Committee conducted investigations in 9 States and the District of Columbia ... which together account for half of America's 23 million aged. Using volunteer Senior Citizen investigators, we developed firsthand information about how some companies take advantage of the fearful aged." (See Select Committee on Aging, Staff Study Report, Exhibit E to Osmer affidavit in support of motion).

The report details the procedures used and the information obtained from questionnaires mailed to every State department of insurance, interviews with five State insurance commissioners and their staffs, a review of all books, periodicals and newspaper references found in the Library of Congress on such insurance, a review of hearings and reports on the subject by congressional committees and administrative agencies, correspondence with all insurance related professionals and trade organizations and a review of all reports and documents provided, correspondence with Senior Citizen organizations asking for their experience with Medicare supplementary insurance, a review of insurance fraud and abuse files of the U.S. Postal Service investigators, every congressional office was asked to save and forward complaints for a period of one month. The staff drafted a questionnaire sent to 250 insurance companies asking for their experience with Medicare supplementary insurance and tabulated the replies, interviewed numerous insurance agents, and staff members obtained jobs as trainees accompanying licensed agents to observe the practices of the agents in the sale of insurance to the elderly, and recruited senior citizens as temporary investigators to test agents and their tactics.

The November 28, 1978 Staff Study report concluded and states in relevant part: "As a result of this investigation, the Committee staff concluded that there are serious abuses in this field which are widespread and require remedial action by State and Federal lawmakers (Report, p. 5).... The unvarnished truth is

that while these companies talk in terms of the best interest of the elderly, they are in reality conspiring to rob them of their meager dollars. The elderly who sought to buy hope, health, and security, are left with empty pockets, anger and further disillusionment. That these practices have gone unnoticed for the past several years is a national scandal only slightly less in magnitude than the schemes of the avaricious companies and their greedy agents." (Report, p. 318).

We turn next to the broadcasts of ABC's three-part series on "Insurance Fraud", telecast on the "World News Tonight" on November 27, 28 and 29, 1978. This court has reviewed the tapes, outtakes and transcripts of the series.

It is evident that only a relatively small portion of the vast amount of information and material in ABC's possession, obtained from the Select Committee and as a result of its own investigation, could be used in the series. The time constraints imposed on commercial television, particularly on a national television network news program, require the exercise of editorial judgment as to what goes out on the air.

The ABC personnel directly responsible for the series were veteran correspondent Margaret Osmer, who was the on-the-air reporter, producer Karen Burns, and Vice President/Executive Producer of "World News Tonight" Av Westin. Also involved were "anchors" Max Robinson and Frank Reynolds, who did the lead-ins and closing statements, before and after each segment of the series.

Plaintiff was not mentioned at all in the November 27, 1978 segment, which was an overview of the Select Committee's Staff Study investigation and report, and a preview of the Committee's hearing to be held the next day, November 28, 1978.

In this first segment, ABC described the abuses found by the Committee Staff as "massive fraud," and charged that there were unscrupulous companies and agents "deceiving, cheating, literally stealing from the people they are meant to help." In support of these charges, brief portions of interviews with volunteer Committee undercover senior citizen investigators and an insurance company agent, who admitted wrongdoing in the sale of insurance to the elderly, were shown.

The second broadcast on November 28, 1978 focused on plaintiff, the acknowledged world-wide leader in the sale of cancer insurance and described by some as the fastest-growing insurance company in the world. Portions of a long sales presentation or "pitch" by one of plaintiff's agents to Select Committee undercover investigators, and taped by ABC's hidden cameras, were shown. Plaintiff's agent was clearly and forcefully preying on the fear of cancer in his pitch. Also shown were portions of an interview with plaintiff's chairman, John B. Amos, at plaintiff's home offices in Columbus, Georgia, during which Amos said:

> "We don't have to sell fear. Fear is there. It's being promoted by the press." And, then, "So I don't think we're playing on fear. We are giving reassurance to people who already are dreadfully afraid of something. We're giving them at least financial security against it."

Osmer said that plaintiff sold approximately 5,000 cancer policies a day, "making a very healthy profit on America's most dread disease." She described plaintiff as the fastest growing insurance company in the world.

There was also an interview with Kathy Gardner, a Committee staff member, who was a former sales trainee of plaintiff, and, herself, a victim of cancer. In Osmer's interview of Gardner, they discussed what Gardner would have received in benefits from plaintiff had she been one of plaintiff's policyholders. Gardner asserted that she would have received a total of $160.00 from AFLAC for her bills of $4,000.00. Osmer then stated that the better companies will pay 80 cents or more in benefits for every dollar of premium and that AFLAC "pays an average of 43 cents on each dollar."

Osmer concluded, "The issue Congress must consider is whether cancer policies like those sold by American Family Life fill a necessary gap in available medical coverage, or whether they play on people's fears with questionable promises of financial security and peace of mind."

The third or final segment of the three-part series, telecast on November 29, 1978, was a summary or recapitulation of the earlier broadcasts. Anchor Frank Reynolds began: "Tonight we have the third in our series of Closeup reports on rip-offs in sales of health insurance to the elderly. In tonight's report correspondent Margaret Osmer has some practical advice."

Next, selected portions of the earlier broadcasts were replayed interspersed with comments by Osmer, who said: "The investigation has turned the spotlight on the abuses in the sale of supplemental health insurance. But it will take time to find effective safeguards against these illegal and unethical tactics. In the meantime, ABC news suggests you protect yourself by looking out for these subtle, but successful tricks in the sale of insurance..."

Osmer pointed out sales techniques which she described as "illegal," including a representation that the salesman was from or somehow connected with Medicare, requiring that the premium check be made out to the agent, selling a different policy from the policy the senior citizen thought had been bought ("switching") and overloading. She recommended a number of self-help procedures, including that senior citizens check on the loss/benefit ratio record of the company and that the company selected should pay at least 80 cents in benefits for every premium dollar. Finally, they were urged to carefully review policy provisions, including benefits, making sure that the policy does not exclude preexisting conditions, or that the old policy does not lapse before the new one becomes effective (where a policy is being replaced).

Osmer concluded with these observations:

> "Medicare will pay on the average thirty-eight percent of your medical bills. If you are able to afford it, supplemental health insurance can substantially defray the other sixty-two percent. However, no insurance will pay for everything. But if you will keep alert to the

malpractices we've cited, and keep yourself well-informed, supplemental health insurance can be a good investment and not lost money."

Anchor Max Robinson then said: "There are almost two thousand insurance companies in America, and the names are often very similar. For example, the company mentioned in ABC News Report last night, American Family Life Assurance of Georgia is in no way connected with American Family Insurance Group of Wisconsin. It's best to check the exact names and reputations with your local consumer affairs office."

Though a number of disputed factual errors were made in the ABC series, such as that AFLAC is the fastest growing insurance company in the world -- plaintiff says in the U.S. -- and was selling 5,000 policies a day in 1978 instead of 3,000 as conceded by plaintiff, or that the elderly were being ripped off to the tune of $2 billion a year instead of $1 billion a year as was estimated by the Staff Study report (some errors originated in the Staff Study report and were repeated by defendants in good faith), these errors were insignificant and irrelevant to the main thrust of the broadcasts. By and large, the series was a fair and true report of the results of the unprecedented and exhaustive investigation conducted by the Select Committee on Aging as set forth in the Staff Study report. This court, as previously noted, reviewed all of the material used by ABC in the series, including the tapes of the broadcasts, outtakes and the transcripts, and

finds that every material and significant statement or charge made by ABC was amply supported by the record, as set forth and documented in the Staff Study report.

Under these circumstances, the ABC three-part series, which is the subject of this lawsuit, was absolutely privileged under New York's Civil Rights Law, Section 74, which provides:

> "A civil action cannot be maintained against any person, firm or corporation, for the publication of a fair and true report of any judicial proceeding, legislative proceeding or other official proceeding, or for any heading of the report which is a true headnote of the statement published.
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> "This section does not apply to a libel contained in any other matter added by any person concerned in the publication; or in the report of anything said or done at the time and place of such proceeding which was not a part thereof."

In Holy Spirit Ass'n v. New York Times, 49 NY2d 63, 67, which was a suit for libel against the New York Times stemming from a Times report of a congressional committee's investigation of the Unification Church, Jasen, J., writing for a unanimous Court of Appeals said:

> "For a report to be characterized as 'fair and true' within the meaning of the statute, thus immunizing its publisher from a civil suit sounding in libel, it is enough that the substance of the article be substantially accurate. As stated by this court in Briarcliff Lodge Hotel v. Citizen-Sentinel Publishers, (260 NY 106, 113):
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> > '[A] fair and true report admits of some liberality; the exact words of every proceeding need not be given if the substance be substantially stated.' (citations)" (See also Freeze Right v. City of New York, 101 AD2d 175, 181-183 [1st Dept., 1984]; and Schermerhorn v. Rosenberg, 73 AD2d 276, 290 [2d Dept., 1980]).

The court in Holy Spirit Ass'n, in affirming the Appellate Division, First Department's order (68 AD2d 833), which affirmed Special Term's order granting summary judgment to the defendant dismissing the complaint (99 M2d 125), held (p. 68):

> "Our conclusion today rests upon the realization that newspaper accounts of legislative or other official proceedings must be accorded some degree of liberality. When determining whether an article constitutes a 'fair and true' report, the language used therein shall not be dissected and analyzed with a lexicographer's precision. This is so because a newspaper article is, by its very nature, a condensed report of events which, must of necessity, reflect to some degree the subjective viewpoint of its author. Nor should a fair report which is not misleading, composed and phrased in good faith under the exigencies of a publication deadline, be thereafter parsed and dissected on the basis of precise denotative meanings which may literally, although not contextually, be ascribed to the words used."

Thus, it seems clear to this court, that the holding in Holy Spirit Ass'n v. New York Times, 49 NY2d 63, supra, is fully dispositive, and defendants' motion for summary judgment dismissing the complaint must be granted.

Though not necessary to this court's determination, this court has considered defendants' other arguments in support of the motion for summary judgment, such as that the series was not substantially false and was broadcast without actual malice.

It is clear that the statements made in the broadcasts, concerning abuses in the sale of supplemental health insurance to the elderly, cancer insurance and the plaintiff, are amply supported in the record, either from the Staff Study report or defendants' own investigation, which was corroborative of the Staff Study report (see Gaeta v. New York News, 62 NY2d 340). Further, defendants are entitled to the benefit of the actual

malice standard inasmuch as plaintiff is either an all-purpose public figure or a limited-issue public figure, and there is insufficient proof of convincing clarity of actual malice by defendants (see Roche v. Hearst Corp., 72 AD2d 245, aff'd 53 NY2d 767), or that defendants' material statements were in fact false or substantially false (see Rinaldi v. Holt, Rhinehart & Winston, Inc., 42 NY2d 369, 380).

Accordingly, plaintiff's complaint, alleging causes of action for defamation, libel and alternatively prima facie tort, and seeking compensatory and punitive damages totalling $175 million, is dismissed. (See Springer v. Viking Press, 90 AD2d 315 [1st Dept., 1982]; Belsky v. Lowenthal, 62 AD2d 319, aff'd 47 NY2d 820).

Settle order.

DATED: MAY 20 1986

J. S. C.